MEDICAID PROGRAM INVESTIGATION
(Part 2)

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SECOND CONGRESS

SECOND SESSION

FEBRUARY 28 AND MARCH 26, 1992

Serial No. 102-137

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U.S. GOVERNMENT PRINTING OFFICE
58-688⇆ WASHINGTON : 1992

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-039189-X

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MEDICAID PROGRAM INVESTIGATION

FRIDAY, FEBRUARY 28, 1992

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Oversight and Investigations,
Detroit, Mich.

The subcommittee met, pursuant to notice, at 9 a.m., in the Wayne State University Student Center Ballroom, Detroit, Mich., Hon. John D. Dingell (chairman) presiding.

Mr. Dingell. The subcommittee will come to order.

Before the business of the committee commences, I would express the thanks of the Chair of the subcommittee to all that have helped make this possible, including Wayne State University and Dr. Adamany. Their assistance has been outstanding. We believe it will help us to gather the facts we need to move forward on one of the great problems that confronts this Nation—the problem of delivery of adequate health care and the deterioration of an already inadequate system that has imposed enormous hardships on industry, individuals and government alike, at all levels.

I want to express my particular thanks to my two dear colleagues on the Committee on Energy and Commerce. The first, Mr. Dan Schaefer, my good friend and colleague, who has come here from Washington but who serves ably the people of the State of Colorado, a State for which I have a particular fondness and a great sense of warmth. Mr. Schaefer is a very valuable Member of the Committee on Energy and Commerce, and he has other qualities that endear him to me, as he very well knows.

The other, of course, our good friend and colleague Mr. Upton from Michigan. Mr. Upton is, again, an extremely available Member of the Committee on Energy and Commerce, and it is to Mr. Upton that I look in many instances for assistance in dealing with some of the savage problems that confront the State of Michigan. I would say, in those matters, neither he nor our good friend Mr. Schaefer have ever been found wanting.

When we have Michigan problems, the fact that Mr. Upton and I do not sit on the same side of the political aisle has never in any way divided us or prevented us from working in close harmony for the welfare of the State and the country.

I also want to thank and express my gratitude to my dear friend, Mr. Conyers, a colleague from the State of Michigan, the Chairman of the Government Operations Committee, one of the most important investigative and legislative bodies in the United States, for his presence today and for his assistance to us. He, like the other three of us here before you, has long been interested in the problem of providing adequate medical care to the people of this country. And, like the other three of us, he is going to be working very diligently to resolve this enormously difficult issue.

I have a lengthy statement which without objection will be inserted into the record. I will summarize it very briefly for the purpose of the hearing so it can be understood.

First, we are troubled about the fact that we have a $1 trillion health bill in this country, with some 35 million Americans receiving no health care whatsoever and some 35 to 37 million receiving inadequate health care.

We are consuming, at this time, 12 percent of the gross national product to pay the costs of providing health care services to the people of the United States. That figure is the most rapidly growing cost item in the American economy, growing at the rate of 12 to 15 percent per year.

By the year 2060, some 100 percent of the gross national product of the United States will be expended on one particular activity—that is, providing health care, leaving nothing for any other human activity, investment or anything else in this Nation.

That is clearly intolerable. Our current system leaves enormous numbers unserved, poorly served, but with still excessive costs to those who do get care

In Canada to the north, 8 percent of the gross national product is spent on health care costs. In Britain, 6 percent. Yet in those two nations, everyone, everyone receives basic health care needs as a matter of right, and their cost containment mechanisms work far better to prevent the kind of economic excesses that we see not only presently but in the future for this country.

The United States has found that its system of Medicaid is not working. This subcommittee has had a number of hearings that have identified fraud, abuse and waste in the system. This hearing will, in part, review those questions. But it will, in part, review a number of other items.

The subcommittee has found excessive charges in billings for Medicaid bills. It has found that there are major problems with regard to health care billings. Some 5 to 15 percent of health insurance claims, according to the Chamber of Commerce, are indeed fraudulent.

Some $50 to $80 billion each year is squandered in wasteful, fraudulent schemes. The total administrative burden imposed on this country, not seen in places like Canada or Britain because of their single-payer systems, is somewhere between $100 and $200 billion of the $1 trillion costs, which, I reiterate, all are going up at an excessive rate.

We are being forced to choose between health care for our people, and different kinds of health care for different classes of people. At this moment health is being rationed by the simple inability of both the system, individuals and our insurers to provide health care for our people. Clearly, that must be corrected.

The United States faces a crisis in this area. It is one which is not coming. It is one which is here. None of the choices before this Nation is easy. None of the choices is going to be without cost. Clearly, if they are faced now and if we understand what we have and what must be done, we can actually come out saving money and having better, fairer and more equitable treatment for our people.

[The opening statement of Chairman Dingell follows:]

Opening Statement of Hon. John D. Dingell

Over the course of the last year, this subcommittee has conducted a series of hearings examining the causes fueling the deterioration of our Nation's health care delivery system, with particular focus on the Medicaid program. We have heard from State and Federal Government officials, providers and community leaders. Unfortunately, the picture that is coming into focus is the unchecked growth of a $700 billion medical-industrial complex that is crippling our economy and shortchanging our citizens.

What we have heard at our hearings is that there are more than enough "villains" responsible for this mess. Many in the industry are too often motivated by avarice. Many patients have unrealistic expectations and continue to want everything at little or no cost to them. Befuddled bureaucrats are choking themselves, providers and insurers with their own paperwork glut. And often well-intentioned policymakers pass laws designed to make more services available to more patients, to save taxpayers' money and to improve the quality of care—only to find, too late, that the laws can have exactly the opposite effect.

In these troubled economic times, the health care industry is unique in its virtually unparalleled revenues and high profits. This system—whether by design or inefficiency—overcharges patients, insurance companies and the government seemingly at will. Despite all the government regulations, and despite all the insurance company and independent audits, some hospitals still charge exorbitant amounts for countless products. One example is the Humana Hospital Corporation, and one of those items is the $103 crutch—for which Humana paid $8. But the crutch was not an isolated case. The costs of 1,500 items were reviewed by this subcommittee. We found that over 40 percent of the items' costs were marked up 500 percent or more, and that almost 20 percent were marked up 1,000 percent or more. Equally troubling is that no one had caught those overcharges. In fact, apparently no one has ever even questioned those bills. None of the oversight mechanisms, redundant systems, and paperwork has identified what the subcommittee believes to be widespread practices throughout the hospital industry—nor has it significantly recouped any overcharges billed to the government. That is a particularly alarming conclusion when the price tag for the administration of these programs is projected at some $4 billion for Medicaid, $2 billion for Medicare and close to $130 billion in the private insurance industry.

Unfortunately, there is still more waste, fraud and abuse in the behemoth that our health care system has become. The Chamber of Commerce estimates that 5 to 15 percent of all paid health insurance claims are fraudulent. Experts warn that between $50 to $80 billion each year is squandered in wasteful and fraudulent schemes. Earlier this month here in Detroit, FBI Director William Sessions announced that 50 more agents will be assigned to ferret out health care fraud. Indeed, the Bureau stated that just as it used an arsenal of sophisticated investigative techniques to address organized crime in the 1980's, similar efforts to combat health care fraud will be critical in the 1990's.

The millions, if not billions of dollars, in undetected fraud could be well spent to reweave a health care safety net for the growing numbers of those going without health care. Those millions could also be used to avoid the $11 billion bill paid by this country's manufacturers to hospitals for care they provide to people who are not eligible for government health benefits or who are uninsured. That cost shifting obscures who is really paying for what, making it ever more difficult to devise effective cost control mechanisms that also protect patients from poor quality care. And it makes it more difficult for our businesses to compete, as the burden is shifted to them at a time that they themselves are grappling with the rising costs of health care benefits for their own employees. furthermore, it creates yet another means for the less scrupulous to hide their overbilling, double billing and other fraudulent financial practices.

Other factors add still more to the health care bill. The deteriorating doctor/patient relationship—which many suggest is a direct result of this market-driven system—has driven up costs. Many physicians and policymakers believe that the so-called "malpractice crisis" has driven providers to practice more "defensive medicine." The Rand Corporation concluded recently that $50 billion a year could be trimmed from the medical bill if unnecessary procedures were weeded out. The "malpractice industry" is blamed for rising costs to the tune of $8 to $30 billion each year. As more and more States—and now the President—call for malpractice reform, the truth is that we don't know the extent to which malpractice litigation forces costs up and whether costs will go down as a result of the types of reform being proposed.

The Medicaid program reflects all these problems, both here in Michigan and across the country. Today is not the first time that we have examined Michigan's mounting problems, and our State's efforts to cope with them. My good friend, Representative David Hollister, recently testified before this subcommittee in Washington on the difficult choices being made here at home. I am acutely aware that our great State—which once could boast one of the best Medicaid programs in the country—is now struggling to maintain even minimum benefits.

As you know only too well, Medicaid has eaten up the State budget—just as it has in other States. Total State health care spending has increased by $2.6 billion since 1981—up nearly 130 percent in 10 years. At the same time, Michigan has lost $10 billion in Federal funding. And local governments have borne 75 percent cuts in real terms. As Federal funding has dwindled, Federal mandates for Medicaid have mushroomed, leaving the States holding the bag.

Making matters still worse, Michigan's economy has suffered tremendous blows. Our State has lost over 33 percent of its manufacturing jobs since 1980. In the all too rare instances in which new jobs have been created, 60 percent of them pay less than $7,000. Not surprisingly, over 1 million people in Michigan—the majority of whom are working—are going without health insurance.

The sad facts of more and more layoffs and budget cuts in Michigan are that new categories of people are in need of social services of all types. Homelessness has taken on new meaning as more of our citizens have family members or neighbors who have been laid off and left with no means to support themselves or their families. Detroit continues to have the highest rate of infant mortality of any city in the country. Without some relief, the health of the people in Michigan who are going without care will continue to deteriorate and the long-term human and economic costs could well be far greater than the cost of any universal health care system we might adopt.

The bottom line is one that no one wants to hear. Some people are going without medical care while others have too much for their own good. Small businesses are hard pressed to afford the skyrocketing costs of insurance for their employees. Larger businesses, State and Federal Governments are left holding the bag, paying the costs for those who do get care but who have no insurance. And, finally, the States are left to make the tough choices of how to slice up the ever smaller budget pie.

Questions and trade-offs abound. Should jobs programs take precedence over health care programs? Do nutrition or substance abuse programs improve the public health more than traditional "health care" programs? What is the real payoff of preventive health care programs—do they warrant more funding than those for organ transplants, experimental procedures or research? Is education more important than health care? Do sound environmental programs contribute more to the public health than the high tech medicine that we have come to expect? How should scarce resources be divided between the working middle class, the indigent or the working poor? What is the proper balance between the needs of the elderly versus the needs of the young?

None of these answers and choices is easy, but we need to find the answers and make those choices now. Testimony by today's witnesses, and statements submitted by others invited but unable to attend, will help all of us address the crisis in the Medicaid program and in the health care delivery system.

Mr. DINGELL. With thanks and gratitude, I now recognize my good friend from Colorado, Mr. Schaefer, for such opening statement as he chooses.

Mr. SCHAEFER. I thank the Chairman and I thank you for the opportunity to be here. I am pleased to be in the great State of Michigan. I wish we had more than one night, but, because of the tax bill yesterday, we all came late. We finally broke some ice in the tax situation, and now have to deal with health care costs.

It is truly a grave situation we are facing in both our private and public health care systems. Increased health mandates have brought shortfalls of money, which has been reallocated from other important programs, such as education. To ensure that Medicaid is fully funded, we have to look for some new ways.

The situation in the State of Colorado is so serious that we have examined the drastic option of discontinuing participation in the Medicaid program. This would mean forfeiture of over $500 million in Federal matching funds.

However, this burden of Federal mandates has forced my State to look at the options. The Nation is facing a great crisis in medical care. How we finance it, both in our private and public health care system, is certainly a problem.

I am pleased to see that the administration has finally put forth a health care proposal and that responsible reform efforts are gaining greater attention on the Floor of Congress. Hopefully, between the two, we will be able to work out something in the near future which will adequately take care of the many millions that are underinsured or not insured.

I am hopeful that today's hearing will help shed some light on this critical situation, and I certainly look forward to the testimony of the witnesses. In particular, I want to see what the individual problems are here in Michigan and try and compare it to what we have in the State of Colorado, and other States throughout the country.

Mr. Chairman, I am pleased to be here today, and I certainly look forward to the testimony. I yield back.

Mr. DINGELL. The Chair thanks the distinguished gentleman from Colorado.

The Chair recognizes our good friend from Michigan, my colleague, Mr. Upton, who works closely, as I mentioned, with the Chair on a number of matters of great importance. The Chair recognizes Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman. I commend you for calling these hearings. In fact, this is one of the few this subcommittee has held outside of Washington.

The fact that it is being held in our home State, of course, heightens my interest, because it serves to demonstrate the subcommittee's strong concern with the failure to provide and maintain an adequate level of health care for our citizens. Clearly our health care system is broken and it needs to be fixed.

We heard testimony in October of 1991 about how rapidly increasing costs of the Medicaid programs have affected State budgets. Indeed, the costs of Medicaid have become a major budgetary concern of the States. They are concerned about recent congressionally mandated expansions in Medicaid populations, arguing that Congress has failed to consider the impact on expansions on already strained State budgets.

States have been forced to do a number of novel approaches, including the use of so-called voluntary donations on taxes on health care providers. I will be interested in hearing about innovative approaches taken by the State of Michigan, both by government as well as the private sector.

The subcommittee has a very full slate today. We are going to hear about problems of access to care, volume of care, and cost of care from virtually all parties concerned—State and local governments, business, health care providers, an advocate for recipients of care, both urban as well as rural.

I would like to welcome Jim Foster, Administrator of the Three Rivers Area Hospital in St. Joseph County, located in the district I represent. He is certainly qualified to discuss the problems faced by rural communities in providing and maintaining adequate levels of health care. Too many times, the rural perspective it seems to me to get short shrifted because the national media tend to focus on the admittedly overwhelming problems in urban areas.

But lack of coverage doesn't mean lack of pain. Mr. Foster is going to demonstrate that that county feels the pain every bit as the urban counties do. Mr. Foster will show us how to raise the constituencies' effectiveness to get together and address the serious problems of health care, access and quality of cost.

I thank the staff and the chairman for putting together the hearing. I welcome the witnesses.

Thank you, Mr. Chairman.

Mr. Dingell. The Chair thanks the gentleman.

The Chair recognizes our good friend and colleague, Mr. Conyers.

STATEMENT OF HON. JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Conyers. Thank you, Mr. Chairman.

I am happy to be here for several reasons. The first is that this was probably a part of Detroit that Chairman Dingell himself once represented, and it is good to have him back in the city. Number two, this is the school at which I obtained some humble understanding of what academic subjects were about, and where I attended law school as well.

So I am happy to be on this campus and to join my friends on this subcommittee on a subject that is very, very dear to me.

The first thing that Chairman Dingell told me is that this is not about national health care. I am happy that he did because he and I are both deeply concerned with that subject, and the question of national health insurance is one that we are both working on.

But this subject is about a matter that the Committee on Government Operations has dealt with on Medicaid, on which we have a GAO report dated from November of 1990, and in March of last year we held hearings in Detroit, in the Federal building, on this problem.

Unfortunately, the GAO report and the hearings dealt with third-party liability and the way moneys are not fully being collected from Blue Cross/Blue Shield of Michigan, and I am happy to have the chance to meet Dr. Vernon Smith of the Michigan Medical Services Administration, with whom we will be having a long and friendly relationship.

The question of Medicaid raises the subject of the health care problems of the medically underserved in Detroit. We are spending through the Medical Services Administration over $2 billion a year, $51 million in the county care program in Wayne County, which after reconsideration on the part of Governor Engler, was reinstituted in the budget. But on analysis by our good friend the attorney general, he found that we didn't fix it up right in the legislature. This is a very important part of this hearing, and we will hear some comments about it from the appropriate witnesses.

The State's Medicaid budget has been rising rapidly for a lot of reasons, and we have experienced a 10 percent increase in the last year. And, at the same time, Michigan's cuts to general assistance, including the attempt to eliminate county care, have created intolerable tensions.

In addition to that, the Medical Services Administration, Chairman Dingell, is trying to enact a state-wide managed care approach for Medicaid, and while it is a legitimate effort to control costs, it is going to present some wrenching problems when we start talking about the medically underserved being put on a managed care-per-capita approach in the delivery of these health services.

In Detroit, the hospital failures are mounting. North Detroit General and southwest Detroit hospitals are both in Chapter 11. As a matter of fact, we are working on a program through the federally qualified health center provisions to examine restoring them as community clinics.

But the fact of the matter is that there are inadequate reimbursements for both Medicare and especially Medicaid. We need to examine for this hearing that 300,000 people who live in Detroit have no health insurance. That is nearly a third of everybody in this city, a rate far higher than the national average. And that is before we figure in the projected cuts and layoffs that General Motors has gratuitously visited upon this city and State.

At the same time, the infant mortality rate in Detroit is that of a Third World nation. We are at 26 deaths per 1,000 births. That puts us right next to Guatemala in terms of an infant being born and living to year one.

We have a very serious problem. I want to thank Chairman Dingell and Sandy Levin, who was at my hearing in Detroit last year, for doing the kind of important oversight work on health that you are doing.

Thank you so much for letting me say good morning in my own way.

[The opening statement of Mr. Conyers follows:]

OPENING STATEMENT OF HON. JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Chairman and members of the subcommittee, it is a pleasure to be with you, here at home today, to discuss what has emerged as one of America's top two economic and social challenges: reform of our ailing health care system.

Today we will hear of the problems of providing and financing health care for Michigan's poor and medically underserved under the Medicaid program. The very fact, Mr. Chairman, that we must hold hearings on this subject is illustrative of a fundamental problem with our health care system: it is a two-tiered system. There is one system for those who can afford private health insurance, and there is another system for those who cannot. Both tiers of this system are failing miserably.

And we are here to talk about money—the precious $2 billion every day, the $84 million every hour, and $23 thousand per second we spend as a Nation under our current system. We have the best health care in the world, but the world's worst delivery system.

Spencing on both tiers of our health care system is expanding at an exponential rate, Mr. Chairman, whether it be for Medicaid or private insurance. In 1991, the Nation's spending on health care reached $738 billion. This constituted: (1) an increase of 10.8 percent from 1990; (2) an increase at a double-digit rate for 4 consecutive years; and (3) an increase more than twice as fast as the 5.1 percent growth rate of the economy last year.

Beyond the impact on families, corporations, health care providers and government that we see every day, out of control health care costs are eroding our ability to compete in world markets—not gradually but rapidly. In 1990 we spent 12.4 percent of our Gross National Product (GNP) on health care. In the same year our trading partners and competitors spent markedly less: Canada 9 percent, Japan 6.5 percent, Britain 6.1 percent. If we do nothing, the percentage of GNP we spend on health care is expected to reach 18 percent by the year 2000—nearly $1.8 trillion.

The cost of doing nothing about our health care system isn't just measured in dollars. It's measured in lives lost and hopes dashed. It's measured by the 35 million men, women and children who have no health insurance today. It's measured in the numbers of closed hospitals and health centers in our cities and rural areas. It's measured in the anxiety of the uninsured and of the American workers who struggle to pay insurance premiums and copayments and avoid changing jobs out of fear of losing their health insurance.

It is indeed a two-tiered system, Mr. Chairman. If you can't pay for health care, for the most part you are out of the system and out of luck.

The upper tier—the system for the 60 percent of Americans who can afford health insurance—is a twisted collection of over 1,200 insurance companies, each with its own set of rules and billing procedures, and without coordination, uniformity, or decent cost control. As one might expect, the costs for the upper tier expand exponentially each year: private insurance costs rose from $73.4 billion in 1980 to $216.8 billion in 1990. And as costs to insurers rise, millions of Americans each year fall from the upper tier to the lower, as working people are priced out of the system and insurers "just say no" to individuals and businesses who are considered bad risks.

The lower tier—the system for the 8 percent of Americans on Medicaid, and the 35 million uninsured, 72 percent of whom are above the poverty level—has become a nightmare for Federal and local governments alike. The Federal share of Medicaid, the focus of our attention today, is projected to grow 203 percent by 1996, to $105.3 billion.

States have it worse: State Medicaid costs in the aggregate accounted for 14 percent of total State spending in 1990 and it is estimated that Medicaid will reach 22 percent of State spending by 1995. So, charged with matching the Federal share of Medicaid, dozens of States in budget straitjackets, like Michigan, are forced to either cut back on Medicaid eligibility or attempt any number of accounting tricks to put up their share.

In the end, it's the people who need comprehensive health care the most that pay. Providing health care to the medically underserved, the disenfranchised, and the unemployed just doesn't have much political support. And so every year Medicaid and other programs for the underserved—like CountyCare, the health care program for Wayne County's underserved who don't qualify for Medicaid—are woefully underfunded.

We say this problem last year when Governor Engler pulled out his budget meat-axe and slashed the General Assistance program and funding for CountyCare. Only after a storm of protest from more principled legislators and citizens was he forced to reinstate funding for this critical program. And now CountyCare is in jeopardy once again after Michigan's Attorney General ruled last month that the legislation reviving the program is unconstitutional.

The result of this lack of financial commitment to health care for the underserved results in trickle down payments to the lower tier. Medicaid reimbursement rates to doctors and hospitals don't cover costs and amount to little more than an assault on providers. Reimbursements are known to be about 55 percent of provider costs. Predictably, inner-city hospitals, like North Detroit General and Southwest Detroit—the majority of whose patients are on Medicare or Medicaid or who are uninsured—go under.

The two tiers of America's health care system are collapsing while their costs explode, Mr. Chairman. In the short term, we can hold hearings like this one, scrape together a little more money, or introduce legislation in a frantic attempt to plug the holes. But the real answer to these problems we will hear about today—the one we must all fight for—is a health care system that insures all Americans under the same policy: a system that provides universal, national health insurance.

The benefits of national health insurance here, Mr. Chairman, would be enormous. Detroit needs it most because we are hit twice as hard as the rest of the Nation. Over 300,000 Detroit residents lack health insurance—that's 27 percent of the city's population and twice the national rate. Detroit's infant mortality rate is twice that of the rest of the Nation, and approaches that of the poorest Third World nations. The average Detroit resident can expect to live 9 years less than other Americans. Few places in America have a more desperate need for a new health system than Detroit.

Mr. Chairman, I am an advocate of a single-payer national health insurance program based on the Canadian model, with modifications to take account of the strengths of the U.S. system. Basically, the Federal Government would provide health insurance to all Americans, just as it provides retirement insurance through Social Security. The program would be administered by the 50 States, whose governments are closest to the people. Fair fees and budgets would be negotiated with doctors and hospitals to further contain costs.

The General Accounting Office, the non-partisan research arm of the Congress, conducted an 18-month study for me on a Canadian-style single-payer system. The GAO estimated savings of $67 billion in 1 year under such a plan by reducing the paperwork morass caused by so many insurance companies. That savings is enough to insure all Americans currently without coverage and eliminate co-payments and deductibles for everyone else. No other health care reform proposal can make such a claim.

Under such a single-payer plan, Americans would still have the freedom to choose the doctors of their choice. Doctors would not be employed by the government any more than they are today. Hospitals would still be publicly or privately run. Hospitals like Southwest Detroit, North Detroit General and others would be relieved of the crushing burden of uncompensated care, as all Americans would have their doctor's bills paid for them. Without the mountains of paperwork and the incessant competition with other facilities, doctors and hospitals could get back to caring for people rather than competing for market share.

I held hearings in Detroit last summer on the need for national health insurance and remain convinced that it is the only way for us to pull ourselves out of the health care crisis. The costs of doing nothing, as we will see today, are far too great.

Mr. Chairman, I would also like to draw attention to the problems of fraud and abuse in the Medicaid system. The Committee on Government Operations, which I have the pleasure of chairing, has investigated problems that State Medicaid agencies have in making sure that insurance companies reimburse the government for care they are liable for.

Federal law requires private insurance companies, such as Blue Cross and Blue Shield of Michigan, to pay health care claims of Medicaid recipients when the private plan covers the service. In effect, Medicaid is the payer of last resort. An example of this kind of coverage is a single parent family on Medicaid where the children are privately insured through the absent parents employer.

Here in Michigan, I had the General Accounting Office, investigate complaints that the Michigan Medicaid agency—the Medical Services Administration—has encountered serious problems in recovering money owed to it by Blue Cross and Blue Shield of Michigan.

The report found that in one 18 month period, from September 1988 to April 1990, Medicaid paid $59 million in claims to doctors and hospitals which by law Blue Cross is potentially liable for. Only $5 million has been recovered from Blue Cross. I am not suggesting that Blue Cross is liable for the full amount, but given the present poor state of the computer interface between Michigan Medicaid and Michigan Blue Cross, we can't tell whether they owe 50 cents on the dollar or 10 cents on the dollar. Whatever the amount, when you consider that all other 49 States have a similar problem it adds up to a tidy sum owed to the Federal and State governments.

The GAO blamed all parties for this mess. The State for not using all its tools to correct the problem; Blue Cross for establishing legal or administrative barriers to postpone or halt payments to Medicaid; and the Health Care Financing Administration, the Federal Agency charged with oversight, which failed to identify the problem and work with the State to correct it.

I am continuing to closely monitor the situation here in Michigan to see what progress the State is making in recouping what Blue Cross owes it, and to limit future losses. I also hope to work with your committee, which has jurisdiction over reforms to Medicaid, to see if we can correct this problem with insurance companies and Medicaid programs across the country.

I thank you for the opportunity to be here today.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair is delighted we are joined by our good friend and colleague from the State of Michigan, the Honorable Sandy Levin who ably represents the State on the Committee on Ways and Means.

All of us here at the table have worked very closely with him on matters affecting Michigan. A fine and respected Member of Congress, and we are honored that he is with us this morning.

He is also a member with major jurisdiction in the area of health and has characterized his term by his concern over these issues. The Chair recognizes the gentleman from Michigan.

STATEMENT OF HON. SANDER M. LEVIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. Levin. Thank you very much, Mr. Chairman. I appreciate the invitation to let me join you. We have a very distinguished number of witnesses, so I will just be very brief.

This hearing is focusing on Medicaid, and the Energy and Commerce Committee under your leadership has jurisdiction over it. The two committees, Energy and Commerce, and Ways and Means share jurisdiction over many other health matters. And though I could not be here for the entire morning, I did want to take advantage of your kind invitation to listen in on some of the testimony between the two committees with the active cooperation and involvement of Government Operations.

We have a big task ahead of us, to try and reform the health care system of this country, and Medicaid is an important piece of it.

So again, to you, Mr. Chairman, to your colleagues and my colleagues from the Republican branch, Mr. Conyers, I am very pleased to be able to join you this morning. Thanks again.

Mr. Dingell. The Chair thanks the gentleman.

The first panel is composed of Mr. Frank Garrison, President of Michigan AFL-CIO, and Mr. David Hirschland, United Auto Workers, Assistant Director, Social Security Department.

The Chair is happy to welcome you to come forward to the witness table. We will be delighted to have your testimony.

The Chair will recognize my old friend, Mr. Garrison, for such statement as he chooses. Welcome. Thank you again. We are pleased that you are here.

STATEMENTS OF FRANK GARRISON, PRESIDENT, MICHIGAN AFL-CIO; AND DAVID HIRSCHLAND, INTERNATIONAL UNION ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT, UNITED AUTO WORKERS

Mr. Garrison. My good friend John, it is good to see you again this morning. It seems like I see a lot of you lately.

Let me express my thanks from the entire labor movement here in Michigan for your timely concern about the problems of health care in this country in general and in Michigan in particular. It is the kind of attention to the problems of people that we in the labor movement have come to expect from your leadership since you have served in Congress.

The problems of health care in Michigan has become acute, particularly over the past year, not because of any natural plague or contagion that has swept our State but from man-made causes, a recession made in Washington and a set of mean-spirited budget cuts in Lansing.

The reckless financial policies of the Reagan-Bush years have finally come home to roost. The mindless deregulations of our financial institutions, the encouragement of speculative lending of depositors' dollars and the laxity of safeguarding the safety and security of deposits have left our financial institutions crippled in their ability to lend and stimulate economic recovery.

More than the tripling of the national debt in 11 years has crippled the Federal Government's ability to respond. We have lost as many jobs in this recession as in any since the Great Depression, and the end is not yet in sight.

Our members were shocked to see that a President who promised to bring a kinder, gentler Nation, last year twice vetoed bills that were passed by Congress to extend unemployment benefits. And, thankfully, he saw the light, and we did pass some extension to the unemployment benefits.

There has been one special feature of this Bush recession, the fact that so many of the newly unemployed have not just been temporarily laid off. Their jobs have been eliminated. And this is true among white-collar workers as well as blue-collar workers. And I can report to you this morning, Mr. Chairman, that I have never seen so much job insecurity among those who still have their jobs as we are seeing in the workplace today.

To make matters worse, just when our social safety net is needed the most, the reckless budgetary policies of Governor Engler have not just weakened the net, they have torn it to shreds. Mental hospitals have been closed and patients dumped into the community without adequate facilities. Emergency need programs established under Governor Milliken and Governor Blanchard have been slashed, and hundreds of thousands of Federal recipients have been cut off, unable to do gainful work, let alone find jobs in this depressed economy.

Let me mention just one case, a 51-year-old widow. When her husband was alive they both were working and they owned their own home. Then he died, and she, after 14 years, was working as a bus driver, was forced to stop working about 2 years ago when she passed out right after work. She was rushed to the hospital and received a pacemaker for an irregular heartbeat.

She still has high blood pressure and difficulty climbing even short flights of stairs. She lost her job and has been rejected for several others because of her health conditions. For a year or so she was receiving $160 a month in general assistance, barely enough to make ends meet. But when John Engler came to office, it was abruptly eliminated. She has lost her Medicaid and her prescription coverage so she went 4 months at a time without blood pressure medicine.

Recently, she spread out for the reporters all the notices of rejections from the Department of Social Services and said, it is affecting me terribly, mentally, physically. All she gets now is $111 in food stamps. And, while her doctors recommend a special diet, she can't afford the items on the diet.

The results of these two convulsions from Washington and Lansing is that, more than ever, people from Michigan have become aware of the inadequacies of our present health care insurance system. Those who are still working are more worried than ever before that they will lose their employer-provided health insurance as soon as they are laid off.

In today's world, an unemployment check will barely cover the cost of a family's health insurance policy, let alone pay the mortgage or the rent and put food on the table. Likewise, in Michigan, there are those unable to work who have all too often been forced to make impossible choices between medicine and food.

Mr. Chairman, you and a few other farsighted political leaders have long been aware of the need for a national universal health insurance with effective means to check the spiraling of health care costs. I am here to report that working people in Michigan, from those with the best existing coverage to those who have none, are ready to work and demand such legislation.

Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman. Mr. Hirschland, we welcome to you.

STATEMENT OF DAVID HIRSCHLAND

Mr. HIRSCHLAND. Mr. Chairman, I am David Hirschland. I am Assistant Director of the Social Security Department of the International Union, UAW. I want to thank you for the opportunity to testify on behalf of the 1.4 million active and retired members of the UAW and their families on the subject of public health issues. I would like to summarize my statement.

Mr. DINGELL. Without objection, your statement will be inserted.

Mr. HIRSCHLAND. The crisis in America's health care system has been well documented. The problems span all aspects of the system, including rising health care costs, lack of access to care, waste and inefficiency in the system, and questionable quality of care.

The UAW believes nothing short of total reform will enable the United States to get a handle on these complex and interrelated problems. More and more of the available income of the people of this country is going to health care costs.

In 1990 the United States spent over $660 billion on health care, which amounted to 12.2 percent of our Gross National Product. In 1991, spending increased to $738 billion.

And the Commerce Department has predicted that Americans will spend $817 billion in 1992, contributing to a record 14 percent of the U.S. Gross National Product. The skyrocketing costs of health care adversely affect the international competitiveness of many businesses and threaten the job security of millions. Older, long established companies are affected because they tend to have a higher ratio of retired workers and an older active workforce, both of which result in higher health care costs.

The UAW believes employers should not have to compete on the basis of their health care costs. There should be a level playing field, with all employers sharing equally in the costs of providing a basic level of health care protection to Americans.

The problem of rising health care costs is aggravated by cost shifting between employers, as well as the growing problem of cost shifting for public programs, such as Medicare and Medicaid, to private employers.

This cost shifting has resulted in a situation where hospitals increase the rates they charge for private payers in order to offset any reductions of public payments or losses due to uncompensated care.

The American health care system is plagued by waste and inefficiency. A 1990 study by the Citizens Fund estimated commercial health insurance carriers spend 33.5 cents for administration, overhead and marketing costs, in order to provide a dollar of health care benefits.

This is 14 times more than the 2.3 cents it costs Medicare, and 11 times more than it costs the national health care system.

While the cost of health care continues to rise, many Americans do not have access to adequate health care services. Over 37 million people are without insurance, two-thirds of whom are working people and one-third of whom are children.

The UAW believes that Americans should be entitled to health care as a basic right. Rising health care costs, and the resulting efforts by employers to cut back on health insurance coverage, have been a major issue in almost every set of UAW negotiations in recent years.

The attempts at cutbacks have affected our ability to assure coverage for laid off and retired workers and their family. Loss of health care benefits for these workers can be devastating.

Mr. Chairman, the interrelated problems of soaring health care costs and declining access to care cry out for fundamental reform. UAW is firmly convinced a Canadian style single payer social insurance program represents the best means of achieving all the goals of flat health care reform.

First, by guaranteeing universal access to health care for all Americans, this approach would serve to improve the health status of Americans. Access to health care would be a basic right, irrespective of health status, employment or income.

Second, by establishing a single government payer, this approach would achieve substantial administrative savings. The waste and inefficiency associated with the existing multitude of private insurance carriers could be avoided.

Third, by establishing a uniform all payers system for reimbursing health care for providers, this approach would eliminate cost shifting between public and private payers. Private employers would no longer have to indirectly subsidize our public health care programs.

Fourth, and perhaps most importantly, by establishing a mandatory, enforceable budgeting process, this type of approach would guarantee that health care spending would be contained within certain limits.

Fifth, a single payer approach makes significant strides towards improving the quality of health care in this country.

In particular, under a single payer system, outcomes in research findings can more easily be fed back into the system in a broad-based effort towards continuous quality improvement.

Sixth, the single payer approach represents the best means of assuring that the costs of providing health care are distributed in an equitable and progressive manner. This type of approach would eliminate cost shifting between employers, as well as the shifting of uncompensated care costs.

A level playing field would be established between all employers, regardless of health status, age, or composition of their workforce. And progressive taxes on corporations and wealthy individuals can easily be used to help finance this type of program.

Mr. Chairman, the UAW appreciates the opportunity to express our views on the public health of this country.

We commend your efforts and contributions. We look forward to working with you and other members of this committee as you struggle with these issues. Thank you very much.

[Testimony resumes on p. 27.]

[The prepared statement of Mr. Hirschland follows:]

STATEMENT OF

DAVID HIRSCHLAND
ASSISTANT DIRECTOR, SOCIAL SECURITY DEPARTMENT
INTERNATIONAL UNION, UAW

Mr. Chairman, I am David Hirschland, Assistant Director of the International Union, UAW, Social Security Department. I want to thank you for the opportunity to testify on behalf of 1.4 million active and retired members of the UAW and their families on the subject of public health issues.

The crisis in America's health care system has been well documented: costs are out of control, access to care is woefully lacking, the quality of care received is questionable, and the economy of the country is being adversely affected. The UAW believes that nothing short of total reform will remotely begin to provide an effective solution to these complex and interrelated problems.

The cost of medical care, which is increasing at a rate faster than the rate for other goods and services each year, is causing alarm for every segment of the population. The Medical Care component of the Consumer Price Index consistently increases at a rate faster than inflation. From May 1990 to May 1991, the MCPI increased by 9.0 percent, while the increase in the CPI was 5.0 percent.

As the country continues to experience these out of control cost increases, and the state of the economy worsens, more and more of the available income of the people of this country is going toward health care costs. In 1990, the United States spent over $666 billion dollars on health care, which amounted to 12.2 percent of our gross national product. In 1991, spending increased to $738 billion. The Commerce Department has predicted that Americans will spend $817 billion in 1992, contributing to a record 14 percent of the U.S. gross national product. The estimated health care bill for 1992 will be nearly double that of 1987, when the total was $494 billion. Without immediate and effective controls, these numbers will continue to soar.

The skyrocketing costs of health care adversely affect the international competitiveness of many businesses, and threaten the job security of millions of Americans. In Canada, for example, employer health care costs are approximately one-half those in the United States; in Japan, about one-third. That kind of disparity is seen as an incentive by multinational corporations to transfer more production and plant investments outside this country.

Escalating health care costs also unfairly affect the competitiveness of older, long established companies compared to newer employers within this country. There are two major reasons for this. First, older companies tend to have a higher ratio of retired to active workers than newer competitors. Thus, the older companies must bear the additional cost of paying for health insurance coverage for their retirees. Second, the average age of the active work force often is higher in older companies than in newer employers. Since health care costs tend to rise with age, this also places an additional burden on older companies. It is extremely important that any reform to the health care system address the disparities related to older and retired workers.

The UAW believes that employers should not have to compete on the basis of their health care costs. There should be a "level playing field," with all employers sharing equally in the costs of providing a basic level of health care protection to all Americans. All employers currently pay the same contribution (i.e., the same percentage of wages) to Social Security in order to provide a basic level of retirement and disability income to workers. The same principle should be applied to the financing of health insurance coverage for workers and their families.

The problem of rising health care costs is aggravated by cost-shifting between employers. Too often, employers that provide health insurance for their workers end up subsidizing those that do not, thereby increasing costs even more. We estimate that 15 percent of the health care costs of General Motors, Ford and Chrysler are attributable to the health care of spouses who are employed elsewhere, but are not covered by their own employer for health insurance. This is on top of the increases borne by the domestic auto companies, like other payers, due to the shifting of uncompensated care costs by health care providers.

In addition to cost shifting between employers, we are also facing a growing problem of cost shifting from public programs, such as Medicare and Medicaid, to private employers. Public health programs have placed limits on their per case costs through the adoption of DRGs for reimbursing hospitals. Private payers have struggled with the resulting cost shift pressures with only limited success. This has led to a situation where, whenever possible, hospitals increase the rates which they charge to private payers in order to offset any reductions in public payments. The net result is that private payers are paying higher rates to subsidize the public programs.

The waste and inefficiency associated with the existing "multi-payer" system also contributes to the constant escalation of health care costs. A 1990 study by the Citizens Fund estimated that commercial health insurance carriers spend 33.5 cents for administration, overhead and marketing costs in order to provide a dollar of health care benefits. This is 14 times more than it costs

Medicare (2.3 cents) and 11 times more than it costs the Canadian national health care system (3 cents). Moreover, between 1981 and 1988, administrative, overhead and marketing costs of commercial insurance companies increased by 93 percent, more than the increase in premiums sold or benefits paid.

While the costs of health care continue to rise, millions of Americans do not have access to adequate health care services. The UAW believes that all Americans should be entitled to health care as a basic right, regardless of their employment or health status, age, income, or place of residence.

The evidence of the declining access to health care is inescapable. Over 37 million people are without insurance, two-thirds of whom are working people, and one-third of whom are children. Nearly 60 million people are without insurance for at least part of the year. Unfortunately, these numbers are not decreasing as the amounts spent on health care continue to rise. In fact, the opposite is true. As health care costs rise, coverage declines, both in terms of the number of Americans eligible for health benefits, as well as the scope of benefits provided to those who remain covered.

Medicaid, the federal-state program developed for insuring the poor, has failed to cover those most needy. Today, Medicaid covers only 40 percent of those living below the federal poverty line. Widely different eligibility standards and Medicaid benefit levels between states undermine the program, as beneficiaries, particularly the working poor, suffer from uneven quality and access, constantly having to face the question of whether one is "in" or "out" of the system. Due to inadequate reimbursement levels, many physicians refuse to accept Medicaid beneficiaries, forcing them to go to overburdened public health clinics or hospitals. Paradoxically, because of the low levels of Medicaid reimbursement, many of these institutions are in dire financial straights or have already closed their doors, further reducing access to care.

For many years, insurance companies and the medical profession assured the American public that voluntary health insurance could accomplish the task of providing health care to the citizens of this country. Indeed, until about 1980, employer-sponsored health insurance covered an increasing number of Americans with an expanding range of benefits. From the early coverage for hospitalization and medical-surgical benefits, protection grew to include many additional services, such as mental health and dental care, as well as preventive health strategies.

By 1980, however, it became evident that a voluntary, employer-based system could not handle the job on its own. For the first time since 1940, the number of Americans with health insurance protection began to fall. Looking for ways to reduce health care costs, many employers began to restrict coverage for their employees. They resorted to a nearly endless array of cost cutting techniques such as: reducing or eliminating prescription drugs, dental, vision, or mental health benefits; adding or increasing deductibles and/or copayments for basic health insurance and/or major medical benefits; introducing or increasing periodic worker contributions for health insurance, especially with respect to coverage for a spouse and dependent children; and reducing or discontinuing retiree/dependent health care benefits before age 65 and Medicare complementary coverage after age 65. Some employers even discontinued coverage altogether. As a result, costs began to shift to other employers and to households. Employers who continued to provide coverage suffered 15 to 20 percent increases per year in their health care costs.

The UAW is justifiably proud of it success in negotiating health insurance benefits for our members and their families. But although most of our contracts provide for excellent health insurance coverage, we still face serious problems in assuring continued access to adequate health care. I can tell you that health care costs, and the resulting efforts by employers to cut back on health insurance coverage, have been a major issue in almost every set of UAW negotiations in recent years. And this problem only promises to get worse.

Even where we have been successful in resisting employer demands for cutbacks in health insurance coverage, we have had to devote an increasing portion of the collective bargaining "pie" to maintaining our health insurance benefits. This means that less money is available for wages and other benefits.

The UAW has also encountered significant problems in assuring coverage for laid off workers. UAW collective bargaining agreements with the major automobile, aerospace and agricultural implement companies provide for continuation of health insurance coverage for a significant period of time after workers are laid off. But due to the lengthy nature of the layoffs in these industries, many of our members have still lost their health insurance coverage. Furthermore, many UAW contracts -- particularly those covering workers employed in smaller parts or other non-manufacturing companies -- do not provide for any extended health insurance coverage. Thousands of UAW members have lost their health insurance benefits shortly after being laid off from these companies.

These workers literally have nowhere to turn. They usually cannot qualify for Medicaid. But having lost their jobs, they cannot afford the exorbitant costs associated with maintaining individual health insurance policies. The COBRA health insurance continuation requirements provide little relief, because most laid off workers cannot even afford the cost of the group rates available under COBRA.

Laid off workers are not the only group who have experienced a threat to their health security. In recent years employers have increasingly attempted to reduce or to completely cancel health insurance coverage for retired workers and their families. This has been exacerbated by several factors, including the changes in accounting rules for post-retirement health insurance benefits which have been promulgated by the Financial Accounting Standards Board (FASB), as well as the competitive pressures faced by older manufacturing companies with higher ratios of retired to active employees.

The UAW has consistently contested employer attempts to cut back retiree health insurance benefits at the bargaining table. And since 1980, the UAW has been involved in numerous lawsuits seeking to prevent reduction or cancellation of health insurance coverage for thousands of retired members and their families. Many of these cases have involved plant closings or bankruptcies.

Where employers have been successful in reducing or eliminating retiree health insurance benefits, the results have been devastating for the retirees. This is particularly true for those retirees and their spouses and dependents who are not yet eligible for Medicare and, hence, are left without any health insurance protection whatsoever. Many retirees cannot replace the lost health insurance benefits. They are considered "uninsurable" by private insurance companies because of their age or physical condition. And even where the retirees are able to obtain new coverage, the cost of individual health insurance policies is usually exorbitant.

Cutbacks in retiree health insurance benefits are particularly cruel because retirement decisions are often predicated, in part, on the promise of continued health insurance coverage for the duration of the retirees' lives. Thus, the cutbacks undermine the legitimate expectations of the retirees. Usually it is too late for the retirees to recoup this type of loss. They are too old to get a new job or start a new career. They are stuck with their hopes dashed, their standard of living during retirement drastically diminished by the cutbacks in their health benefits.

The sad truth is that the various attempts to cut back on coverage have done nothing to contain the increases in health care costs. They have only served to shift the burden of health care costs to employees. Meanwhile, the underlying causes of health care inflation -- a fee for service system for reimbursing health care providers and provider-driven over utilization of services -- continue to plague us.

The Bush Administration, rather than dealing effectively with the inadequacies of the existing health care non-system, appears to be intent on pursuing the fanciful "solutions" cherished by the Reagan Administration. These "solutions" include taxation of benefits, means testing, caps on government spending for existing programs, managed care for Medicaid recipients, and encouraging IRA withdrawals to pay for current health care costs. Relying mistakenly on cost-shifting to reduce demand, these proposals would only aggravate existing problems and further reduce access to health services. The UAW believes that curing the problems of the system will not happen merely by revisiting pious old prescriptions or invoking an imagined "competitive, free market" for health care.

The UAW has represented workers in Canada for many years and has come to see the many advantages of their national health care program. The Canadian system, which is based on a federal-provincial partnership, provides comprehensive health insurance coverage to all citizens in a cost effective manner.

The UAW is firmly convinced that a Canadian style single payer, social insurance program represents the best means of achieving all the goals of national health care reform.

First, by guaranteeing universal access to health care for all Americans, this approach would serve to improve the health status of Americans. Universal access to a basic package of health insurance benefits would assure that all citizens have access to adequate health care services. Individuals would no longer have to fear that they may lose their health care simply because they are laid off, change jobs, or their employer goes out of business. Access to health care would be a basic right, irrespective of health status, employment or income.

Second, by establishing a single government payer, this approach would achieve substantial administrative savings. The waste and efficiency associated with the existing multitude of private insurance carriers could be avoided. Estimates of these savings range from 30 to 100 billion dollars. The General Accounting Office recently issued a report which estimated that a Canadian style single payer system would save about 67 billion dollars -- enough to pay for the cost of extending health insurance coverage to the 37 million uninsured.

Third, by establishing a uniform all payers system for reimbursing health care providers, this approach would eliminate cost shifting between public and private payers. Private employers would no longer have to indirectly subsidize our public health care programs.

Fourth, and perhaps most importantly, by establishing a mandatory, enforceable budgeting process, this type of approach would guarantee that health care spending would be contained within certain limits. The budgeting process would involve all of the players -- providers, consumers, and the government -- in determining what the reimbursement rates should be for various types of services and what the aggregate level of expenditures should be. All parties would then be required to live within the agreed upon budgets. Our nation already utilizes a budgeting progress to determine how we allocate our resources for national defense, infrastructure, and every other social good or service. It is time we adopted the same approach with respect to the delivery of health care services.

So-called voluntary goals or targets are no substitute for mandatory, enforceable budgets. Unless all parties are required to live within the agreed upon budgets, we will never achieve the discipline needed to contain rising costs.

The UAW also believes that the budgeting process should apply to capital expenditures, as well as payments to physicians and hospitals. Capital budgeting should encompass expenditures for expensive new technology, in addition to investments in new buildings. Only through this type of mechanism can we hope to eliminate excess capacity and over-reliance on state-of-the-art technology, and begin to establish priorities for the allocation of our health care resources.

We also believe that any budgeting process should retain incentives for the development of managed care delivery systems. It is important that we continue to build on our positive experiences with managed care and encourage the adoption of preventative and holistic approaches to medical care.

Fifth, a single payer approach can make significant strides towards improving the quality of health care in this country. In particular, under a single payer system, outcomes research findings can more easily be fed back into the system in a broad-based effort towards continuous quality improvement. This, in turn, can help reduce costs by eliminating much of the unnecessary and inappropriate medical treatments which are currently being provided to patients. Throughout the reform process, improving the quality of care that Americans receive must remain a top priority. As the twin crises of runaway inflation and lack of access to health care in the health care system continue to worsen, the quality of care received by millions of Americans remains suspect.

Recent studies have shown that ten to thirty percent of selected medical procedures are performed inappropriately or unnecessarily. And gross indications of health status, such as infant mortality and life expectancy, indicate that the quality of health care is lower in the United States than in many other industrialized countries.

The UAW believes that outcomes research findings are critical to correcting these problems. The key to improving and ensuring quality of care is the collection and study of data for the purpose of determining optimum treatments for optimum outcomes. Data analysis should take place at the national level, to promote a further understanding of issues such as regional practice patterns and the steps toward elimination of unnecessary and harmful treatments which are currently being provided to patients.

Sixth, a single payer approach represents the best means of assuring that the costs of providing health care are distributed in an equitable and progressive manner. This type of approach would eliminate cost shifting between employers, as well as the shifting of uncompensated care costs. A "level playing field" would be established between all employers, regardless of the health status, age, or composition of their work force. And progressive taxes on corporations and wealthy individuals can easily be used to help finance this type of program.

Mr. Chairman, the health care system in the United States must be fundamentally reformed. Every industrialized nation, with the exception of the United States and South Africa, has some form of a universal, national health security program. This is not a goal attainable only through the sacrifices of our personal freedoms and liberties. When the ideological smoke screens are stripped away, we know that individuals in Canada, Great Britain, Sweden, West Germany, Italy, France, and other free societies are guaranteed basic health care protection by law. It is time for the United States to join the rest of the world in assuring this basic protection to all Americans.

Again, Mr. Chairman, the UAW commends you for your leadership in the struggle for a fair and equitable health care system. We appreciate this opportunity to express our views on this critical subject and look forward to working with you and the other members of this Committee as you struggle with these difficult issues. Thank you.

Mr. **Dingell**. Mr. Hirschland and Garrison, the committee thanks you for your very valuable help and your statements in consideration of the matters we have before us.

The Chair will recognize first my good friend from Colorado, Mr. Schaefer, who has come a long way at substantial inconvenience to himself to be with us here today.

Mr. **Schaefer**. I again thank the Chair, and am glad to be surrounded by such able members of the Michigan Delegation today. I say that because in the State of Colorado, some 4 years ago, we were faced with tremendous unemployment problems, industry losses, and a lot of the same industrial situations you are in today. We had these problems. We are slowly trying to come back, but we want to try to make sure the same not happen in the other States, if at all possible.

Last spring, the chairman led a delegation to Detroit of which I was a part—and I thank you for the great lunch we had—and it was very informative.

I would like to ask this question: Health care benefits have become an increasing part of collective bargaining. Are we getting increased wages or additional health care benefits?

Mr. **Garrison**. Let me try first. I am headed for your great State this morning when I leave here.

Mr. **Schaefer**. Spend a lot of money.

Mr. **Garrison**. Going out and watch one of the next Presidents of the United States-to-be. It is becoming one of the major issues in collective bargaining for every union. When they go to the bargaining table, health care sits front and center. The last round of negotiations with communication members, it was the health care that created the strike they had at Bell Telephone. Everywhere we look, it is health care.

Mr. **Hirschland**. I don't see people negotiating to improve health care benefits. I haven't seen that in the last 13 years. What I see is people trying to hold on to the health care benefits they have and if the cost of health care benefits becomes an issue, to the extent changes are made, they are in the other direction.

Mr. **Schaefer**. In other words, you are seeing more of a bargaining point to get additional or to keep your health care rather than the wage issue.

Mr. **Hirschland**. Right. Really, people would like to improve their benefits. That is not the direction things have gone.

Mr. **Schaefer**. Now, you both mentioned national health care. I have had some problems with that in the past because I feel that there is a possibility to deteriorate the quality of health care if we go in that direction. Would you care to comment on that? Is that a concern?

Mr. **Garrison**. We are the only industrial nation in the world except South Africa that doesn't have some form of national health insurance. Our competitors, our major competitors on trade, have some form of national health insurance.

You know, these countries, they are not complaining in Canada about quality of care. They are not complaining in Germany or Japan. All over the world, they have adequate health care coverage for the national system. I don't see why we can't have one in this country.

Mr. HIRSCHLAND. Let me add to that. If you look at traditional measures, very gross measures of quality, two things you might look at are infant mortality and life expectancy. Many countries of the world have higher levels than we do.

Second thing, you talk about quality of care, it is very hard to measure quality of care, because we have so many different providers. One of the things a national system will allow us to do is have a uniform way of looking at quality.

Medicare has recently taken some important steps to doing that, but Medicare doesn't represent all the health care in this country; far from it.

Mr. SCHAEFER. I know we have tremendous problems. We in Congress passed a catastrophic bill sometime back, and turned around and repealed it. The Members of Congress are branded with that and they don't want to jump into a new program too fast without making sure it is going to work. That is why I ask these questions, because something we don't want to see happen is less quality in care.

Mr. HIRSCHLAND. In our current system, we have people who don't have care and, clearly, their quality of care is virtually nonexistent. We have people having a very difficult time getting access to care. We have problems because we are reimbursing inadequately; providers aren't providing everything they should.

We have a lot of quality of care problems in our current system. If we have uniform sets of benefits across the Nation, where we didn't have different tiers, that would be a good step towards making sure we improved our quality of care.

Mr. GARRISON. Mr. Schaefer, rushing into it? My God, the chairman's dad introduced a bill when Franklin Roosevelt was President. I don't know that we are rushing into it.

Mr. SCHAEFER. I understand that and I understand it has been around for a long, long time. All I am saying to you is that a lot of members, because of the catastrophic health care problem, are a little bit worried about trying to come out with a novel approach that does not work.

That is all I am saying. It is one of those things, almost like banking and the S&L's. We are afraid to go into banking reform unless we know exactly what is going to happen. We don't want this to repeat itself.

One other question, Mr. Chairman. What kind of choices are being made by the workers? Must they sacrifice protection for themselves, long term, for the health care? If we were going to nationalized care, would we also include long-term health care, as well as dealing with the immediate problems of your workers today?

Mr. GARRISON. Well, that is why the labor movement in this country supports a comprehensive, you know, program that will cover everybody, you know, from cradle to grave.

Mr. SCHAEFER. Costs are tremendous.

Mr. HIRSCHLAND. That is certainly true. One of the problems we have in costs right now, in addition to having administrative systems which are extremely expensive and not productive, we can't budget health care costs right now. If we had a national system, we could talk about what we are going to spend on national health care.

Mr. SCHAEFER. I appreciate the gentlemen's answers. These are questions we are concerned with.

Mr. DINGELL. The Chair recognizes now the gentleman from Michigan, Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman. How would you characterize the quality of health care under the plans you have negotiated?

Mr. GARRISON. Again, each union has different coverage, depending on their contract. And even though the UAW is mostly a home union, but even within that union, it depends on which company you are negotiating with. It is not a uniform health care coverage throughout the labor union or any one union. In the auto industry, it is probably one of the best packages you can get.

Mr. UPTON. I want to hear from you. What specific steps have you taken to control the rising costs of health care? Do you have special programs for smoking; or weight loss? How do you deal with preventive care?

Mr. GARRISON. Let me, Mr. Upton, reply. For instance, at Kellogg, the grain millers union in Battle Creek—that is not in your District, but there they have negotiated the kind of things you are talking about. They have a health care system there. They have got a wellness center on site for the workers.

Mr. UPTON. They have Raisin Bran.

Mr. GARRISON. They have Raisin Bran. But again, there was negotiating between the union and management to have a wellness program to cut down on health care dollars, and it seems they have worked.

Mr. UPTON. Are you seeing that type of program pretty much across the board?

Mr. GARRISON. I think you are seeing it more and more discussed. I am also a board member of Blue Cross-Blue Shield.

Mr. HIRSCHLAND. I think there is a lot of use now of wellness programs. When you are describing problems where you try to keep people well by improving diet, getting blood pressure under control, weight loss, smoking. We see that in the employment system now and the programs have a lot of promise.

The impact of those tends to be long-term, but we have certainly encouraged them. We have a lot of those programs. They tend to work best when they are developed locally. We have seen it at Chrysler, Ford, and General Motors. A lot of the smaller units now.

That has really been going on since 197—late 1970's. At one time, companies really weren't very interested in that. Only more recently have they found that is a promising area.

Mr. UPTON. Mr. Hirschland, the devastating news that came out this week with regard to closing plants in Flint, Willow Run, a number of others, what is going to happen under contracts you all have with those folks that will be laid off? What type of safety net may be in those programs—what specifically may be happening to those families?

Mr. HIRSCHLAND. I am not familiar enough with the General Motors contract to tell you what those people might do, because they have rights to hopefully move to some other plants and things like that. We do have extended health care coverage for lay off, particularly for longer service employees.

Mr. UPTON. Do you know if those families will be eligible for Medicaid?

Mr. HIRSCHLAND. You probably know the rules better than I do, but there is an income test and means test. Those people will not initially be eligible for Medicaid. They will have employer continuation coverage for a substantial period of time.

Mr. DINGELL. Will the gentleman yield? On the question of eligibility, the probability is these people will be covered with continued benefits from GM through the duration of the contract. They would not meet the means test or the property owners test, because most of these factory workers are good, stable people who own their own homes.

Mr. HIRSCHLAND. I think one of the things that happens at the point when somebody comes for Medicaid financially, every bad thing that can happen to them has happened. Particularly when you look at the coverage levels of people that are clearly below the poverty level.

Mr. UPTON. In closing—I know my time is about ready to expire here. I am a little concerned about the Canadian health plan. I represent the other side of the State, southwestern corner, central southern part, and as I have examined the Canadian health system, I see a lack of choice of physicians, which I am not sure in many cases people here would want to see; I also see long waiting lists for important procedures, like bypasses.

Rural areas—it may work better in urban areas. I represent a relatively rural District. We have seen the closing of many health facilities.

Mr. HIRSCHLAND. I guess I have a different opinion than you do, Congressman. In terms of choice, my understanding in Canada, there is choice of physicians. And one of the problems that we have—if it is not in your District, it is fortunate. In many rural areas, there is lack of access in this country. It is less true in Canada than it is here. There are many parts of the country where it is very hard to get access to health care and health care providers, because in rural areas, people like to practice less.

You take a look at where you find physicians, the concentration for physicians per population and you compare rural areas to urban areas and suburban areas. In rural areas, that coverage is worse.

Mr. UPTON. In regard to heart surgeons, there is one in Canada for every 2.1 million Canadians; we have one for every 304,000 Americans. MRI's, we have more in the State of Washington than in Canada.

Mr. GARRISON. Mr. Upton, let me ask. You talk about choice of doctors. Ask Congressman Conyers what choice the inner city people have; there is no choice for the poor in this country or the people who are unemployed and can't afford to go shopping for doctors. There is no choice. At least in Canada you can go see a doctor. A lot of people in this country don't have the ability to see a doctor.

Mr. HIRSCHLAND. Let me add to that. When you talk about MRI's and number of heart surgeons for the population, let me identify some of the problems we have. We have many more MRI's than we need. We are paying for those because that is a capital expenditure.

People start running the MRI's whether they are necessary or not in order to be able to recover their capital costs. Somebody has to pay for that.

As far as heart surgeons is concerned, there has been, appropriately so, more of an emphasis on primary care in Canada than there has been here. We have been oriented towards specialists because of our reimbursement system. What the exact numbers are, I don't know. I do know there is more of an emphasis on primary care physicians in Canada than here, and that is appropriate.

Mr. UPTON. Do you think that—there are employees that have a contract—decent contract with health benefits, would they rather give that up and change that for the Canadian system? Do you think the quality of care under the Canadian system will be better?

Mr. HIRSCHLAND. I believe our members understand how fragile the health care coverage they have is. They recognize it is employment-based. They recognize their employers in many cases are in fragile situations.

Unfortunately, in my 15 years with UAW, I have been in a place where I went in with employers who had very good health care benefits; unfortunately, the company went out of business or was sold, and 1 or 2 years later, these people had no health care coverage. They understand how fragile that is. I think our membership is very supportive of a national health care program.

Mr. UPTON. Do you think they would give up the specific program they might have under the existing contract for a Canadian type system?

Mr. HIRSCHLAND. We represent Canadian workers in the UAW and still represent some. The workers who we represented in Canada seemed very well-satisfied with the system they had there and, if anything, more satisfied than the workers in the United States.

Mr. UPTON. Mr. Garrison.

Mr. GARRISON. I was just going to mention what David just mentioned. We have done polling in Canada because many of the unions have membership in Canada, and we find repeatedly the workers in Canada are more satisfied with their health care coverage.

Mr. UPTON. I yield back.

Mr. DINGELL. The time of the gentleman has expired. The Chair recognizes the other gentleman from Michigan, Mr. Conyers.

Mr. CONYERS. Mr. Chairman, thanks—I am not going to ask many questions, but this is the panel that I really want to express my appreciation to for starting off this discussion.

When I held my hearings last year, Tom Turner, Treasurer of AFL-CIO, testified for the Garrison organization, and Ernie Lofton—Mr. Hirschland was with Ernie Lofton when he testified for UAW. I think it is very important that they be commended for the kind of discussion we have generated here today.

The two issues that are on my mind are, first of all, the Canadian experience in terms of how much health insurance cost per car is being carried there, as opposed to how much the cost of health insurance for every worker and retiree at UAW is being carried right across the river here in Detroit, and we know what it is.

Lee Iacocca, not only is the labor movement telling us—that is what you get for mentioning Lee Iacocca. When Lee Iacocca tells you what the cost of health insurance is on a Chrysler built in Detroit as opposed to one being built in Windsor, you know this issue is now larger than just collective bargaining. The difference is 500 bucks and rising, per car. That means that we are at a serious disadvantage in terms of international competition. If either of you want to enlarge on that, you can.

Mr. HIRSCHLAND. I think you have actually said it all, Congressman. We are at a tremendous disadvantage competitively. I would add to that, we are really not getting any benefit for that.

Mr. CONYERS. The question to my friend, Frank Garrison, is, first of all, to thank you and the labor movement for being concerned about the status of health in America beyond your union borders. Someone asked us what would the UAW worker want to give up, not paying premiums in the big plants at all. They are covered in the collective bargaining agreement.

Owen Beiber answered this question more directly than anyone I have heard. He said, "My people are committed to national health insurance, universal coverage, single payer." He said, "Because in the long run, that is where we are going to end up."

In every collective bargaining agreement, the big sticking point isn't even wages anymore, it is health benefits. The issue is, how much are you going to give back? You are never going to gain one thing more. It is how much are you going to give back because of the rising administrative costs.

Our current health care system has 1,200 insurance companies with thousands of policies and the madness that that involves. And so, when Garrison talks about the problems of people not in the labor movement, that is illustrative of the national questions here.

Thirty percent of Detroiters are already without a stitch of insurance, and anybody that is kicked out of General Motors has to be destitute to get Federal assistance. To qualify, you cannot own a house. They will make you sell your car. You are on the skids before you can qualify for Medicaid.

I just want to say thank you for advocating on behalf of everybody that doesn't have a great union job in this city, and there are more and more people that are in that fix. It is important that we can come here and talk about them, as well as what is good in labor.

Mr. GARRISON. That is a rich tradition of this movement.

Mr. CONYERS. I thank you very much, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman. The chair recognizes now our good friend from Michigan, Mr. Levin.

Mr. LEVIN. Thank you, Mr. Chairman. Just very briefly, whatever plan one favors, the worst plan is the status quo. The hearing this morning already has captured that. By the way, it isn't always that Energy and Commerce and Ways and Means are represented at the same hearing, with Government Operations also. I think that symbolizes how the pieces are really interrelated here.

The failings in Medicaid spill over into Medicare, into the private health system, and any approach that doesn't look at all of the pieces, whatever the conclusion, is going to miss the target.

I close by reminding us in this State, we should need no reminder. Our present health system is costing us competitively $1,000 a car, more or less, here in health insurance in each automobile, versus $400 to $500 in other countries. Every time a car comes off an assembly line, it is already $500 behind the competition. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman. Mr. Garrison and Mr. Hirschland, your testimony has been very helpful to us. We thank you for being our lead-off witnesses. It is a pleasure to see both gentlemen.

We will be working together on this health problem, as you very well know, as we have in times past. Thank you very much for being with us.

The Chair announces that our next panel is one which I think is going to be of enormous interest to the subcommittee. Mr. Walter Maher, Director of Federal Relations for the Chrysler Corporation, and Mr. Patrick Farver, Vice President, Blissfield Manufacturing Company.

Gentlemen, we thank you both. Mr. Farver has come from very far away. Your testimony we look forward to with considerable interest.

We are recognizing you first, Mr. Maher. If you will identify yourself for the purposes of the record, you may proceed.

STATEMENTS OF WALTER B. MAHER, DIRECTOR, FEDERAL RELATIONS, CHRYSLER CORP.; AND PATRICK D. FARVER, VICE PRESIDENT, BLISSFIELD MANUFACTURING CO.

Mr. MAHER. Thank you, Mr. Chairman. My name is Walter Maher. I am Director of Federal Relations for the Chrysler Corporation. We appreciate your holding this hearing.

There are a lot of Johnny-come-latelies to this issue. Mr. Chairman, you have been at it for a long time, and I think we are getting a lot closer than we were before. I also appreciate the fact that we have so many members here because I would like to have this opportunity to share our opinion on the existing health care system and its impact on the economic and physical health of this country.

The root of this problem is cost. And the critical factor is that because we lack a health system in this country, a health policy, we don't have the tools to address a health policy. And, as a result, the problem grows, and it is crippling our citizens and our economy in two key ways.

First, and we have already heard a lot about this this morning, it burdens U.S. manufacturers with enormous costs that are totally disproportionate to comparable costs borne by our foreign competitors. In the case of my industry, our costs are more than twice those of German manufacturers and three times those of Japanese health costs.

But, second, and we don't hear enough about this, this entire burden, including all health costs, ultimately falls on the back of the American consumer and American citizens, squeezing too many out of the system, and squeezing the standard of living of those fortunate enough to have health insurance, through out-of-pocket payments, taxes to finance Medicare and Medicaid, higher prices, lower wages, less job opportunities.

Consider for a moment a very real-life example of how health costs impact manufacturers. If you assume that health costs in this country were evenly distributed through the economy, a U.S. business, and this is any U.S. business, competing with a Japanese firm, a U.S. firm offering health benefits would start out with a 131 percent health cost penalty. But you then pile on cost shifting from the government, and the penalty compared with foreign firms gets worse.

For example, as you know, Mr. Chairman, Medicaid covers only 40 percent, Medicaid covers only 40 percent of the portion, and even for those it does cover, it pays doctors and hospitals two-thirds of their costs. The residue gets shifted to the private sector.

You compare the private sector, and the penalty for foreign firms gets worse yet. Two-thirds of those without insurance in this country either have full-time jobs or are dependents of people with full-time jobs.

So rather than spreading health costs through retail and service firms which have little foreign competition, we shift costs to manufacturers who do, because they are the firms who most often offer health benefits and whose employees frequently have spouses or dependents employed in the retail and service sector.

Finally, adding insult to injury, the U.S. health system penalizes a business for its longevity. The older your workforce, the more costs you have to bear.

If my country went over to France, Germany, Japan and built a factory, we hire a local workforce, we pay prevailing wages and benefits. Our costs would be substantially the same as our French, German and Japanese competitors and would be identical in France. Even though our workforce in those countries would be younger, we would have no retirees in those countries. Why? Because in those countries businesses pay for health care on a payroll tax basis.

Conversely, when foreign auto firms come to this country and offer health plans, they can offer comparable wages and benefit programs but enjoy a significant health-cost advantage simply because of employee demographics.

These transplant operations employ a workforce about 12 years younger on average and are a generation away from beginning to accumulate numbers of retirees. This gives them a major cost advantage they have not earned, and it is simply a product of our health care system.

And the result, as Congressman Conyers pointed out, the difference, the gap between our spending for health this year and a Japanese firm in Japan will well exceed $500 per car. And, putting that in perspective, my company's complete costs have exceeded $500 per car only four times this century.

That is a fact of life. If Americans want to be the best and most efficient economy in the world, we have to take strides to rid our economy of these burdensome excesses.

Now, the private sector has been hard at work on this problem for years. But it is important to note that businesses large and small are finding out there are clear limits to what they alone can do in response to this problem, other than managing their benefit programs as effectively as possible.

Simply put, the best managed care or coordinated care plan in the world remains exposed to government cost shifting, remains exposed to cost shifting from other employers not offering coverage, the excesses of our malpractice system, and all of the other excesses of a system lacking fiscal discipline. However, employers, who after the government are the second largest payers, find that they are often in the position to do the same thing that the government is doing, and that is shift cost.

Consider for a moment that an employer who wants to remain an employer has to recover its cost. Accordingly, to get relief from health cost, employers are adding to prices to the extent the market permits. They are reducing the rate of wage growth to the extent the labor market permits. They are increasing deductibles and co-payments and reducing benefits to the extent the labor markets permits. They are hiring fewer people, locating jobs offshore.

They also earn less money. And when they do that they pay less taxes which reduces the funds that State and local and Federal Governments have available to meet other societal needs. They pay less dividends which reduces the standard of living of shareholders. And they have reduced capacity to invest in R&D, training, et cetera.

All of this falls on the back of John Q. Public who doesn't have the ability to shift cost. And that leads to them either getting squeezed out of the health care system or the deterioration of their standard of living. And a citizenry either squeezed out of the system or squeezed of disposable income doesn't make for a healthy society or a vibrant economy. And a sound economy is important to all businesses who wish to succeed in a global marketplace.

Therefore, Mr. Chairman, we commend you for this hearing. The businesses of America, large and small, who offer health plans, need Congress, need the administration to focus on this issue and take the steps that are necessary to rectify the social and competitive inequities.

Thank you very much.

Mr. DINGELL. Mr. Maher, that is a very impressive statement. We thank you.

[Testimony resumes on p. 60.]

[The prepared statement and attachments of Mr. Maher follow:]

STATEMENT OF

Walter B. Maher
Director - Federal Relations
Chrysler Corporation

I appreciate the opportunity to share with you our views on the existing health care system and its impact on the nation's economic and physical health. In particular, I am pleased to comment on how the current health system is substantially penalizing U.S. manufacturers engaged in foreign competition, how it is eroding the standard of living of American citizens, and how it is contributing in a major way to the continuing recession in the country.

BACKGROUND

Starting first with basics, it is the inexcusably high cost of health care in America which is at the source of all our concerns regarding the plight of the uninsured, the ruinous costs to federal and state budgets, to businesses and to families, and the damage to our economy.

If the cost of our health care system was reasonable, by any rational standard, and the only problem we had was that the poor did not have access to it, the focus of remedial action would be much different.

If the cost of our health care system was reasonable, by any rational standard, and the only problem we had was one of quality, the focus of remedial action would be much different.

However, the problem here is cost, and like a cancer it spreads and causes countless other complications, some equally fatal.

That we have a problem controlling health costs in America should surprise no one, for it is a direct result of the fact that this nation, and this nation alone, lacks any sort of process to control aggregate health spending.

There is overwhelming evidence that health spending in America is clearly out of control. We spend 43% more per capita than the second most expensive country (Canada); 81% more than number three (Sweden). The situation is even worse when we are compared with Germany and Japan, home of our major international trade competitors. Were we to consume health services in America at the same rate they do in those countries, we would have over $300 billion per year available to redeploy in our economy (Exhibit 1). This exceeds our entire defense budget. How would that be for a "peace dividend!"

Health costs cripple our economy in two key ways. First (and we hear a lot about this) they burden U.S. manufacturers with enormous costs totally disproportionate to comparable costs borne by our foreign competitors. In the case of autos, our costs are more than twice those of German manufacturers and three times those of the Japanese. Second (and we do not hear enough about this) all health costs ultimately fall on the back of the American consumer, through the cost of copayments, deductibles and out-of-pocket payments; through taxes to finance Medicare, Medicaid and other publicly financed programs, including health benefits for public employees; through higher prices; and through lower wages and less job opportunities. Consumers with less disposable income do not make for a dynamic economy.

QUADRUPLE WHAMMY FOR MATURE FIRMS:

Consider the impact health related expenses have on manufacturers, in general, and my industry in particular:

- If health costs were evenly distributed throughout the economy, a U.S. business competing with a Japanese firm would start out with a 131% health cost penalty (Exhibit 1). I emphasize, this is a penalty any business offering health benefits bears, if they encounter competition from Japan or any other foreign nation.

- Pile on cost shifting from the government, and the penalty compared with foreign firms gets worse. Example: Medicaid covers only 40% of the poor, and even for those it covers it pays doctors and hospitals only about 2/3 of their costs. (See attached Wall Street Journal article.)

- Pile on cost shifting from the private sector, and the penalty compared with foreign firms gets worse yet. Example: 2/3 of the uninsured have full time jobs or are dependents of people with jobs (Exhibit 2). Rather than spreading health costs through retail and service firms, which have little or no foreign competition, we shift costs to manufacturers, who do face brutal foreign competition, because they are the firms who most often do offer health benefits, and whose employees frequently have spouses or dependents employed in the retail and service sectors.

  Note: A recent report on Employer Cost Shifting Expenditures prepared for the National Association of Manufacturers by Lewin/ICF revealed that 28% of U.S. manufacturers' health costs were accounted for by cost shifting from government and other employers.

- Adding insult to injury, the U.S. health system penalizes a business for its longevity. The older your workforce, the more retirees you have, the higher your costs. Example: If Chrysler built a plant in France, Germany or Japan, and paid its workers the same wages as established French, German or Japanese manufacturers did, its health costs would be substantially similar (and identical in France) to those of its competitors, even though the Chrysler workforce would undoubtedly be younger, with no retirees. Why: because in those countries business pays for health care on a payroll tax basis. Conversely, when foreign firms come to our country and open plants, they can offer comparable wage and benefit programs, but enjoy a significant health cost advantage, simply because of employee demographics. These "transplant" operations employ a workforce about 12 years younger on average, and are a generation away from beginning to accumulate numbers of retirees. That gives them a major cost advantage they have not earned; it is simply a product of our health care system (Exhibit 3).

THE RESULT FOR CHRYSLER: The difference between our spending for health this year and a Japanese firm will well exceed $500 per car. Putting that in perspective, Chrysler's total profits have exceeded $500 per car only 4 times this century!

WHAT BUSINESS CAN DO

The private sector has been hard at work on the health cost problem for years. In mid-1981, Chrysler established America's first Board of Directors'-level committee devoted exclusively to analyzing Chrysler's health care cost problem and searching for solutions. Since that time, a substantial number of cost management initiatives have been adopted and even more actions are planned. We have a significant percentage of employees enrolled in HMOs, PPOs, Exclusive Provider Organizations and various other "managed care" programs. Despite these actions, Chrysler has seen its per capita cost of providing health coverage to employees and retirees increase at an average annual rate of about 8 percent since 1981. While this was substantially better than the average business' experience, it nevertheless represented a rate of increase which exceeded both CPI and GNP growth.

Businesses are finding there are clear limits to what they alone can do in response to this problem, other than managing their benefit programs as effectively as possible. **Simply put: the best managed health care plan remains exposed to government cost shifting, to cost shifting from employers not offering coverage, to the excesses of our malpractice system and all of the other excesses spawned by a system lacking fiscal discipline.**

Sadly, however, because we do not have a health policy in this country, not to mention a system with fiscal discipline, we lack coordination between public and private sector health plans. As a result, government, the single largest payer, has the opportunity to control its spending by using its legislative and regulatory powers to (1) define Medicaid eligibility in ways which lead to millions of Americans being denied access to appropriate health services at the appropriate time and at the appropriate site, (2) pay physicians and hospitals less than fair fees for providing care to the poor and, in some cases, the elderly, and (3) defining the Medicare benefits package in a way which causes substantially all seniors having the resources to do so to have to purchase a Medigap insurance policy thereby generating substantial confusion, administrative hassle and expense for seniors as well as for providers. In one way or another all of these actions lead to costs being shifted to private sector payers.

Employers, the second largest payer, are in the position to do the same thing . . . shift costs. Certainly many employers, and most large employers, try their best to manage their health benefits programs. However, consider for a moment that an employer, who wishes to remain an employer, must recover its costs. Accordingly, to get relief from health costs employers:

- Add to consumer prices to the extent the market permits.
- Reduce the rate of wage growth to the extent the labor market permits.
- Increase deductibles and copayments or reduce benefits to the extent the labor market permits.
- Hire fewer people.
- Locate jobs off-shore.

They also:

- Earn less profits.
- Pay less taxes, which reduces funds available for other societal needs.
- Pay less dividends.
- Have reduced capacity to invest in R&D, training, etc.

All of this impacts individual citizens. It is clearly contributing to the growing awareness among Americans that it is they who ultimately bear the brunt of a health system without fiscal discipline.

A citizenry squeezed for disposable income coupled with a weakened business community do not make for a vibrant economy. A sound American economy is vitally important for those American businesses who wish to succeed in a global marketplace.

Quite clearly, therefore, if American manufacturers in general, and American auto manufacturers in particular, are to be a force in the world economy in the 21st Century, immediate Congressional action is required to rectify these competitive penalties. We submit the need for reform of our health care system has been well established. But what direction should this reform take? First, we need to establish some objectives.

Our objectives should be a health system within which the necessary health care needs of all citizens are met; a system which consumes resources prudently, balances spending on health with other national priorities, spreads costs over the broadest possible base and does not disproportionately impact any segment of the economy; and a system which exists in a context of continuous quality improvement.

To accomplish these objectives certain principles are key:

EQUITY AMONG PAYERS

This obviously is only an issue were health system reform to involve something other than a single-payer system. For example, some reform proposals envision a public/private partnership building on today's employment based model for those in the workplace. Under such a reform policy, tax financed plans would be available for all the poor and elderly. This would address one piece of the cost shifting dilemma faced by the private sector. Further, however, given the government as a "partner", a process is required to establish fair provider fees for fee-for-services medicine, and such fees must be applicable to both public and private sector payers. This would close the cost shifting loop, at least insofar as the government is concerned.

EQUITY WITHIN THE ECONOMY

If we are to rely on employer financing in the future, all employers must participate. This can be done without harming weak or deterring start-up enterprises and without encumbering established employers with unreasonable costs and FASB liabilities. To help accomplish this within a public/private reform strategy, any employer (or individual) should have the choice of either purchasing private insurance or paying a tax no greater than its appropriate share of the cost of a community rated premium unadjusted for age, thus permitting enrollment in a publicly financed health plan or a choice of such plans. This will help assure costs are spread across the broadest possible base in our economy and that no sector of the economy or no employer bears a disproportionately large share of expenditures.

The payroll tax provisions of any such reform proposal should be primarily based on what is an appropriate health tax for a U.S. employer which needs to remain competitive in world markets. There is no reason why the sole source of support for such publicly financed health plans need be payroll taxes and individual premiums. The much more critical needs are for the program to be administered efficiently, for health services to be rendered efficiently, maximizing the use of quality driven organized delivery systems, and for costs to be distributed fairly throughout the economy, including support from employers and employees.

Further, with respect to the tax rate, in the interest both of distributing the cost of health care as broadly as possible through the economy, and of keeping the costs of American producers competitive with foreign firms, employees should contribute their fair share of the cost of the system. In Germany, for example, the employer and employee share the payroll tax which finances the health system on a 50/50 basis. In Japan, the comparable employer share is typically about 60%.

Finally, we should not lose sight of the fact that insurance companies, certainly large insurers, can play a major role even in tax financed health plans. Further, this role need not be limited to purely administrative (as is much of the work of Medicare fiscal intermediaries). For example, private insurers play a major role in the Federal Employees Health Benefit Plan.

FISCAL INTEGRITY

No nation on earth has embarked on a program to provide all citizens access to health care without concurrently adopting a strategy to control aggregate national health care spending. Such management of spending should extend not only to spending for health services, but spending for capital items and graduate medical education as well. Control over aggregate expenditures is critical. Any reform strategy which fails to acknowledge this fact will without doubt fail to balance health spending with all of our other societal needs.

Finally, in shaping a health system for the 21st century, America should strive to become the best. We agree with the recent GAO report regarding the Canadian health system, that we should not feel compelled to adopt Canada's or any other nation's health system, lock, stock and barrel. Many nations, including Canada and Germany, believe they are spending too much for health care and are looking to build on their systems by adopting some of the good elements of the U.S. system. We should do the same. For example, Canada is exploring the use of organized health care delivery systems; but there is no consideration being given by Canada, or any other country, to dismantling its controls over overall system costs.

OBSTACLES TO REFORM

Unfortunately, there are many obstacles to systemic reform. For example, a major problem the health system reform debate must contend with is how to address the legitimate concerns of the very small business person. Seventy-five percent of U.S. businesses employ fewer than ten persons. The majority of them do not currently offer health coverage. They represent an obstacle to universal access if employer-based coverage is to be the chosen financing vehicle.

Clearly, a mandate that all small employers buy private insurance is not the best alternative. Requiring a small, marginally profitable, low wage paying firm to pay the same amount for a standardized benefit plan as the largest, most prosperous corporation would pay is a strategy we do not see employed by any of our leading foreign trading partners. Understandably, therefore, when such strategies have been suggested in the past the small business community opposed them and, more often than not, urged Congress to take steps to make health insurance more affordable.

Enter: Pay or Play; a financing strategy designed to ease the burden on small employers. Given a 7% payroll tax, an employer paying the minimum wage could enable a worker to choose a quality health plan by paying a 30 cent per hour payroll tax. Try as we may, it is not likely we will succeed in driving private insurance rates down that low! The response by small business organizations to such a proposal: opposition; opposition even to comprehensive reform proposals incorporating tough cost containment provisions, provisions assuring quality, assuring insurance and malpractice reform, assuring expansion of private sector oriented, competitive organized delivery systems . . . all because such proposals seek to have all employers in some way participate in the financing of this nation's health care system.

If the concerns of these employers cannot be satisfied because of worries about tieing health coverage in any way to employment and the resulting impact on hiring and production costs, and as a result the health system reform needed by all employers, including many small employers, currently offering coverage is stalemated, then we believe it would be appropriate to reconsider the tie to employment and move to a fully publicly financed system.

On a related note, while much attention has been given to the concerns of small businesses, as noted earlier similar attention should be accorded the problems of mature companies. Many such firms have been in business well over 50 years, were extraordinarily labor intensive (and still are to a lesser extent), and now have many retirees and older workforces reflecting a combination of the firms' years of existence, continued automation and foreign competition. With the U.S. increasingly battling in a global economy, we must revisit rules applicable to U.S. firms which differ from rules applicable to our major trading partners. For example, rules or practices relating to the way employers help finance the provision of health care to employees and to pre-age 65 retirees, and the way businesses must account for such costs. By focusing all our attention on small businesses we run the risk of becoming a nation of start-up companies, which gradually over time lose their markets to foreign owned producers.

There have been other road blocks to reform. Some approach myth status. For example, "managed care" is often cited as an alternative to a tax financed system as if they were mutually exclusive. They are not. The manner in which a society chooses to deliver health services to citizens and the manner that same society chooses to finance the delivery of care are distinct issues. Clearly, "managed care" is a valid cost control strategy and should be encouraged. Medicare today, or the entire Canadian system for that matter, could be 100% managed care. The Federal Employees Health Benefits Plan could be 100% managed care. We must not, therefore, let "managed care" become the "Voluntary Effort" of the 90s and stifle the systemic changes that are necessary. More significantly, however, regardless of how low "the market" can drive down prices, any governor or Congress, desperate about their respective deficits, can legislate them lower and shift costs to an employer in the process.

Another issue currently in vogue is insurance reform, chiefly with respect to small businesses. Insurance reform is essentially an insurance policy holder payment equity issue. Huge penalties currently paid by many small policy holders will simply get spread among other policy holders. It promises little, if anything, to control aggregate U.S. health costs or improve the plight of the uninsured. It is not a bad idea; but we must not delude ourselves it is a panacea.

Another myth, a classic red herring, is that any control over aggregate spending will cause citizens to stand in line for services as health care is rationed. This "your money or your life" threat is contained not so subtly in many outcries from some in the provider and insurance communities and is as bogus as it is unworthy of its proponents. It clearly fails to differentiate between a budgetary process and the size of the agreed upon budget. The distinction is important.

First, we should never fear rationing excess; instead we should seek to eliminate it. More fundamentally, however, having a "budget" process does not necessarily imply deprivation or queues. It is simply a function of how much a society chooses to spend on health or anything else. If you have a large enough budget for Medicare or any other population, you can get instant gratification. The key is to create a process where citizens can choose where they want to spend their resources. The alternative to a budget is not to have one . . . to have no control on spending. Yet this is what we have today and it is the reason spending for health is soaking up so much of our nation's resources, leaving less for other needs.

Having a budget process is important, for in America, like Canada and elsewhere in the world, citizens mainly pool their money to buy health care. Here we do it through the tax system and by purchasing insurance. In Canada its virtually all through the tax system. In neither country, however, do individual citizens take out their wallets or checkbooks and pay for health services rendered in the normal course of events. In both countries, some other party is usually responsible for all or most of the bill.

Accordingly, given the subject matter of the transaction . . . life, death, pain and suffering; given the fact citizens pool their money to pay for it thus destroying any semblance of a market which could normally be expected to efficiently allocate resources; given a private sector, entrepreneurial minded, medical-industrial complex "selling" to such "consumers;" absent some legislated process to control aggregate expenditures you are assured the entrepreneurs will win and you will have runaway spending . . . precisely what we have in America today. **In all other fields of commerce, save health care, entrepreneurs must confront limits . . . typically measured by the amount of a consumer's disposable income. This forces choices. In health care today, the choice is automatic . . . the dollars go to health care regardless of consumer or payer wishes. Everything else gets rationed! This must change.**

COST OF INACTION

Americans are clearly not aware of the growing costs they continue to bear as a result of inaction . . . as a result of failing to step up to the need to reform our nation's health care system. Barring change, we believe health costs will easily exceed $2 trillion by the year 2000 and absorb over 20% of our nation's GDP. Health costs are growing far faster than family income, than business income, than local, state or federal government income (i.e., tax receipts). The result: a steady reduction in citizens' standard of living as health care absorbs more and more of our citizens' and our nation's resources and saps the strength of its businesses.

For example, in 1991 45% of the growth in our economy was accounted for by increased health spending.[1] Even given the Administration's forecast for an improved economy in 1992, health spending this year will consume almost 14% of our GDP and, more significantly, new spending on health will drain at least 31% of every single dollar of economic growth.

This is happening without a vote of the people because our nation lacks a health policy, lacks a system to address the problem. This is the result of inaction.

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[1] While this high percent was undoubtedly aggravated by the slow growth in our economy, the slow growth was itself caused in part by the burden health expenditures impose on the economy.

TWO REFORM OPTIONS

To put such a system in place, we see two options. Both would foster a pluralistic, private-sector-oriented, competitive health care delivery system. Both would assure access to affordable health care for all residents. Both would embody a process for the determinations of fair provider reimbursement, with the result binding on all fee-for-service payers. And both would have a process to assure control over aggregate health spending.

One option would be financed by building on the current public/private model. The other would be financed principally through the tax system. Chrysler could support either model.

With reference to a public-private model, Chrysler has been working with The National Leadership Coalition for Health Care Reform. The Coalition is made up of businesses from many varied industries, unions, health care professionals, and consumers. It is committed to effective reform of the health care system.

Last month the Coalition announced its proposal, the result of over eighteen months of effort to forge a consensus. This comprehensive proposal, which seeks a public-private partnership, incorporates as one of its features a "pay or play" financing strategy for those in the workplace.

Chrysler can support The National Leadership Coalition proposal because it makes clear the need for the public and private sectors to work in a coordinated fashion; because it makes clear the need to provide access to affordable health care for all citizens; because it establishes a process to control aggregate health costs; because it eliminates cost shifting from the public to the private sector; because it embraces the concept of community rating; because it allocates costs equitably across the economy to help insure a competitive business environment; and because it underscores the need for prompt action. The Coalition's proposal, if enacted now, would save over $1.8 trillion by the end of this decade and over $600 billion per year starting in the year 2000. It is a proposal which is good for all sectors of this economy and particularly for the uninsured and for those in the private sector who have been bearing the brunt of cost shifting. It is a proposal which is doable and which, ironically, would still find the U.S. with the highest per capita health costs in the world. So, clearly, the savings achieved do not come at the expense of the quality of care available to Americans.

The businesses of America, particularly our manufacturing base, need this type of health system reform now. The citizens of America need this type of health system reform now to help them regain the standard of living they have seen erode over the past decade. We need to take the hundreds of billions of dollars our health system wastes each year and make it available for redeployment in our economy, investing to educate children, to enhance the skills of our workers, to improve our infrastructure, and to make our domestic industries more efficient. In short, to help meet the needs of all citizens and our economy in general.

We pledge to work with you and any others who are willing to make this type of vision a reality for our country.

EXHIBIT 1

HEALTH SPENDING PER CAPITA

	1980		1990	
	$	% U.S. Higher	$	% U.S. Higher
United States	$1,089	-	$2,566	-
Germany	$ 704	55%	$1,287	99%
Japan	$ 522	109%	$1,113	131%

Source: Organization for Economic Cooperation and Development: Facts and Trends

THE WALL STREET JOURNAL MONDAY, DECEMBER 9, 1991

Cost Shifting: How One Hospital Does It

By Sidney Marchasin

Tinkering with Medicare and Medicaid constantly goes on in Congress and in state legislatures, usually for the purpose of reducing payments to hospitals and physicians. When lawmakers vote to cut reimbursements for Medicare and Medicaid, they believe they are contributing to overall containment of health-care costs. It's true that these actions slash the price of medical care paid for by federal and state governments. But when legislators fail to shoulder the true costs of buying health care for the elderly and the poor, they invite the transfer of expenses to the private sector. In other words, those of us with health insurance are paying twice to care for the elderly and the poor: through taxes and through our insurance premiums.

According to the American Hospital Association, more than half of U.S. hospitals will lose money on Medicare this year. In a practice known as "cost shifting," these institutions will boost their charges to private paying patients to make up for the shortfall. When hospitals escalate their charges, insurance companies, in turn, raise their premiums.

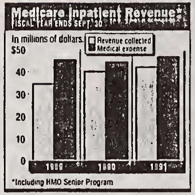
Cost shifting therefore widens the inequities in health care. With insurance premiums spiraling out of control, many middle-class families and businesses can no longer afford to buy into the market. Cost shifting amounts to a covert secondary tax system—one that major corporations and small businesses are increasingly unable to bear.

Pricing Health Care

To see how this works, take the example of my hospital, Sequoia, a 430 bed nonprofit in the San Francisco Bay area. At Sequoia, Medicare and Medicaid payments have fallen well below our operating costs in the past five years. To remain solvent Sequoia has increased its charges to private patients. The financial data from my hospital, as seen in the accompanying charts, are not unique. They are a microcosm of trends observed in the nation's approximately 5,000 general hospitals.

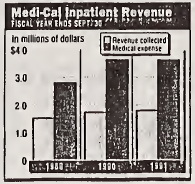
To understand the "cost shift" phenomenon it is important to understand that since 1983, Medicare reimbursement to hospitals amounts to a system of price controls. The government allocates a hospital so much money for treating a patient with pneumonia, so much for caring for a patient with a heart attack. Moreover, fees per diagnosis are established—not negotiated—allowing Uncle Sam to impose a revenue cap or a ceiling on the care of each hospitalized Medicare beneficiary. If a hospital can treat a patient for less than the government's fee schedule, it earns a profit. If it spends more than Uncle Sam's allotment, it eats the difference.

Hospitals agreed to support this fixed-price-per-patient payment scheme when lawmakers pledged to give institutions fair, annual rate increases to compensate for both inflation and new technologies. The promise has been drowned in a sea of red ink. Congress has taken an ax to Medicare and quietly butchered the program in the name of fiscal solvency.



*Including HMO Senior Program

At Sequoia, operating costs increased between 7% and 10% annually between 1983 and 1991. During this same period, Congress allowed only a 2% to 3.5% annual increase in Medicare reimbursements. Since almost half of our hospital revenues come from our Medicare business, the failure of government to keep pace with inflationary costs has had dramatic consequences. In each of the past five years Sequoia has spent more money taking care of Medicare beneficiaries than it has received in reimbursement. In the past three years we have lost $20 million on Medicare.

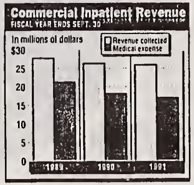


Medicaid, which is called Medi-Cal in California, accounts for only 3% to 4% of Sequoia's annual revenue. The institution is reimbursed for the care of Medicaid patients at approximately 50% of its costs. We have lost a total of $6 million on Medicaid beneficiaries in the past three years.

These losses have occurred despite efforts to improve efficiency, maintain high standards of care and reduce clinical personnel. Like all hospitals, Sequoia has a limited capacity to deal with inflation. Almost 60% of institutional costs are for labor, and hospitals are compelled to accept rising labor costs because of the increasing scarcity of skilled health care workers, such as nurses, pharmacists, physical therapists and other professional staff.

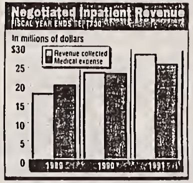
To recover its losses from the underfunded Medicare and Medicaid programs, we have been obliged to raise our charges to nongovernment customers.

Indemnity plans (i.e. commercial insurance companies that pay the hospital's usual fee for each item of service) are bearing the brunt of the cost shift. Between 1989 and 1991, trying to make up for our $26 million loss from Medicare and Medicaid, Sequoia charged commercial insurers $24 million more than the actual costs of its services. This enormous cost shift to the private sector and revenue from outpatient business enabled us to stay in the black for two of the past three years.



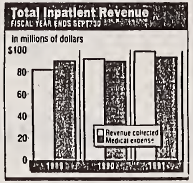
As we've discovered, operating margins from an in-patient business of almost $100 million per year are slim. To stave off financial disaster, large corporations are demanding bargain rates from hospitals and doctors: they are steering their patients to institutions and physicians that offer their services for substantial discounts. Here at Sequoia, negotiated policies are capturing a larger share of the health market while indemnity insurance is diminishing in market share. The hospital's narrow profit margin from negotiated contracts reflects the hard bargaining stance of corporate America.

Small employers, by nature of their size, lack leverage in the health care market. They are unable to evade the cost shift by entering into negotiated care contracts.



They are, therefore, compelled to purchase indemnity policies and accept lofty premium increases. Worse, they can be forced to abandon their coverage, thus producing more uninsured patients.

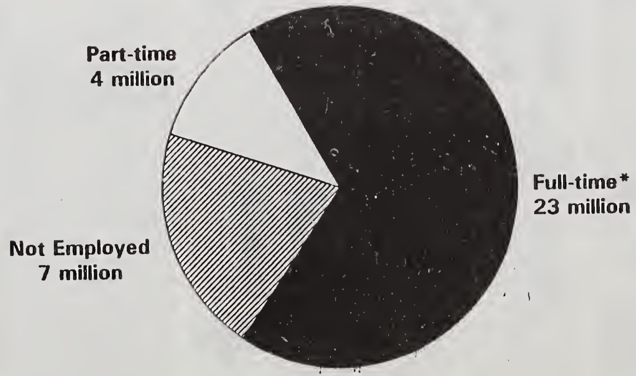
In a National Center for Policy Analysis report issued in November 1988, John Goodman estimated that more than nine million people lack health insurance because current government policies have increased the price of insurance to a level they cannot afford. Perhaps the ultimate irony is that many of the uninsured got that way because government-induced cost shifting has priced low-cost insurance out of the market.



Dr. Marchasin, an internist, is chairman of the board of Sequoia Hospital, Redwood City, Calif. Arthur Faro, the hospital's CEO, contributed to this article.

EXHIBIT 2

The Majority of Uninsured Americans Are Employed Full-Time



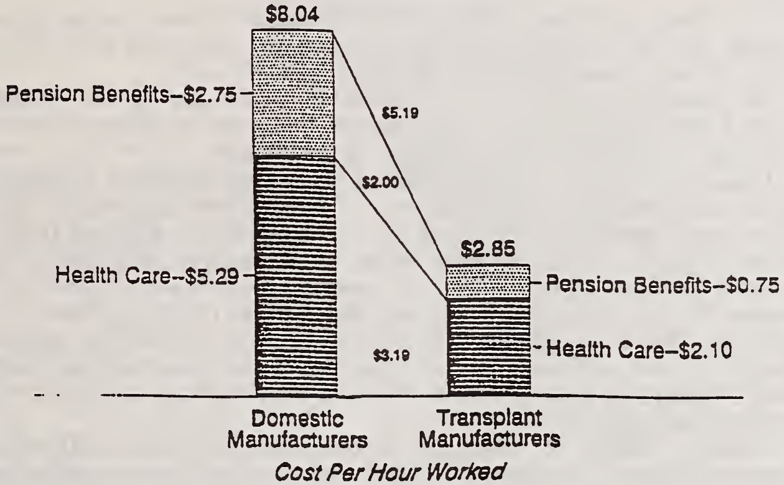
Uninsured by Employment Status, 1990
(34 million)

Source: Karen Davis
Johns Hopkins University, 1992

*Full-time = 35 hours per week

EXHIBIT 3

Domestic Vs. Transplant Pensions And Health Care



Mr. Dingell. Mr. Farver, we are appreciative of your being here. Will you give your full name for the record?

STATEMENT OF PATRICK D. FARVER

Mr. Farver. Thank you, Mr. Chairman.

My name is Patrick Farver, I am vice president of Blissfield Manufacturing Company in Blissfield, Michigan.

I guess I am here representing the little guy. I do have an opening statement which is a brief summary of my total statement which I would like to include in the record.

Mr. Dingell. Without objection, your full statement will be inserted in the record. We recognize you for such comment as you wish.

Mr. Farver. Thank you, Mr. Chairman. Good morning and thank you for the opportunity to share my thoughts with you on the problem of escalating health care costs.

My family's business was started 46 years ago by my grandfather. I am the third generation in the business and hope to be able to bring my sons into the business in the future.

One of if not the most frightening things we face as a company is the uncontrollable rise in the cost of health care insurance. We at Blissfield Manufacturing Company have always recognized that the most important and valuable asset is our people. We have many people that have been with our company 30, 35 and as long as 45 years. We also have many fathers and sons working together in our facility. We have always taken care of our employees and our family, if you will, and, in turn, they have taken care of us. That is why we have been in business 46 years and continue to be a strong, successful company.

But our ability to take care of our employees and still remain competitive and profitable is dissolving quickly. The uncontrollable rise in health care costs have drastically affected our profitability. We have been forced to put more of the burden on the employee and in some cases reduce the level of benefits we provide. For the first time in 46 years we have to consider having our employees contribute to the cost of health care premiums. The costs have risen at such a rate that our sales, growth and cost-reduction programs cannot keep pace with the increases in health care costs. We still offer a program that is better than most, but our ability to continue that practice is quickly diminishing.

I strongly feel that companies that take proactive measures to increase the wellness of their employees through education and prevention should be given incentives to continue these practices, while companies that don't should be penalized. By practicing prevention and maintenance of health care, we take many of the people out of the already overburdened system.

Health care needs to get back to its roots of being a service to the people and not a vehicle to generate huge profits for insurance companies and unscrupulous people that would abuse the system for their own personal gain.

Thank you, and I would be happy to take any questions to the best of my ability.

[The prepared statement and attachment of Mr. Farver follows:]

BLISSFIELD
MANUFACTURING COMPANY
626 Depot St • Blissfield Michigan 49228 • Phone 517/486-2121 • FAX 517/486-2128

TESTIMONY
OF
PATRICK D. FARVER
VICE PRESIDENT
BLISSFIELD MFG. CO.

Blissfield Manufacturing Company is a 46 year old family owned corporation. We employ between 200 to 250 people with all operations combined. We started out in a 5000 sq. ft. building in 1946 and now occupy a little over 400,000 sq. ft. The main focus of Blissfield Mfg. Co. business is the refrigeration, automotive, off road and construction equipment markets.

Blissfield Mfg. Co. has always believed its most valuable and important asset was its people. As stated earlier we are a family business and have tried to treat all of our employees as we would our family. Blissfield has always and continues to offer its employees an excellent benefit package including major medical, optical, dental and prescription drug coverage. Up until a few years ago the company paid all costs and all employees had first dollar coverage. Due to escalating costs we were forced to change the salaried employees benefits to an 80/20 co-pay situation. As you can see from the attached graph our costs on an average have gone from around $ 500 per year per employee in 1968 to close to $ 6000 per year per employee in 1992. The most dramatic changes coming in the last 10 years. The costs are out of control. How can the small business in America compete in the world market when they have no control over these outrageous costs increases. We can go through many cost reduction programs and implement new methods of manufacture but there is no way these things will keep pace with the ever increasing costs of health care. At what point does the cost of health care surpass the hourly wedges we pay our people ? Looking at the last ten years it won't be long. Under the current system I can foresee people working for benefits and not hourly wedge or salary considerations.

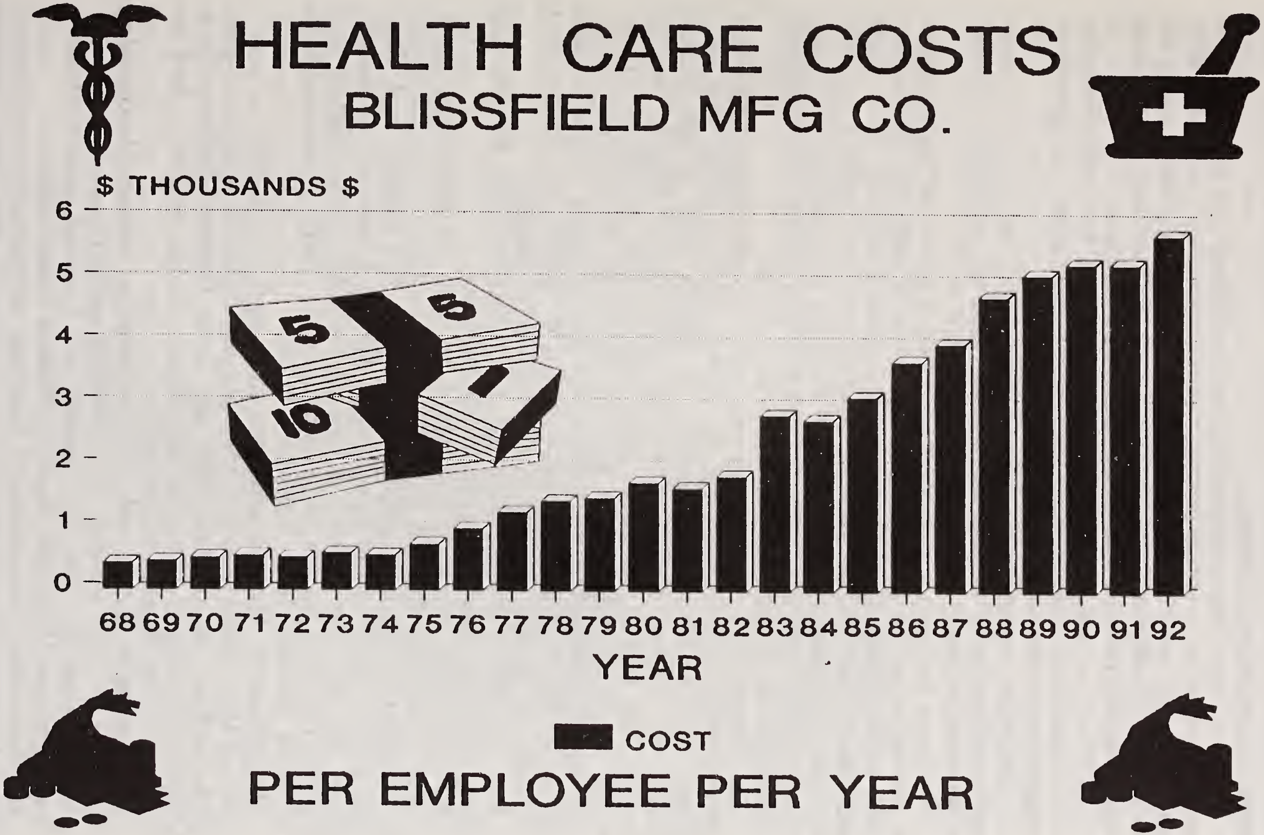
The stress on the working people is also intense. As the costs of health care keeps sky rocketing peoples attention turns to worrying about their ability to survive an illness or injury that may cost them beyond their current coverage. Productive time and attention to the job at hand is thus diluted. Also this health care cost problem continues to erode the working relationship between management and labor. As costs continue to rise, management has to find ways to control this escalation.

In most cases this leads to reduced benefits as well as increased cost burden to the employees. In some cases the employer has to turn to different programs for different groups of employees based on union/non union, salaried, hire dates and a host of other options. This is hard to administer and also fosters ill feelings among employees that one group may have more or better benefits than another.

I think that there is a much larger and more far reaching problem that the health care issue is a major part of. That is the question of what is really morally right in our society. Has the operation of the business become so hardened and a slave to the almighty dollar that all compassion and consideration for human casualty is forgotten. If we look at the overall impact a Business like Blissfield Mfg. Co. has on a small community such as Blissfield Michigan the overall picture becomes a bit more complicated than just health care costs. We currently pay approximately 30% of the taxes and employ many of the local people both in the factory as well as the office. The money they make buys homes and local services that also generate taxes and income to the community. They in turn support the local retail business who also pay taxes to the community and so on. The point being that if costs get to the point that they threaten the existence of the business or the benefit level has to drop to stay competitive, you may loose employees. The schools, the retail businesses, the suppliers, the doctors, lawyers, and every person in a community feel the after shock of a business closing or cut back in one way or another. Its a huge domino effect that is felt through the community.

Now lets consider the effect on those men and women that work all their lives and build up a pension for retirement. With the supplemental health care needed in most situations the cost often exceeds the monthly pension. What are these people supposed to live on. The costs have gone so high that many opt not to have any insurance due to the high cost. This is like Russian roulette. They hope they won't need the insurance but the probability is that they will. What a way to spend your "Golden Years" worrying about if you can pay the medical bills. The stress of the worrying is enough to make them sick.

Somewhere along the line our society has drifted away from what made our country great. Independent people working together for the benefit of all. We have become so engulfed in the money and profits and material gains that we have lost sight of what is really important for the long run. The focus has to turn back to people helping people. The government can't administer the health care system. They can't even deliver the mail cost effectively so how can they expect to administer and control the health care system effectively. It is just another invitation for abuse and corruption. We need to put the control back at the local level. Let the communities work together to provide health care to their citizens. Their are many small communities of excellence that need to be modeled. Focus on the good that is being done rather than what is always wrong. If we continually focus on the negative we will continue to produce negative results. Find the good and focus on what is right and build from there. We are still the greatest nation on earth and if we redirect our focus to the things we do right in the health care system and how to best serve all the people instead of how to complicate the process and allow huge profits at the expense of the working people we will find the RIGHT solution. Prevention, Education and incentives for those that are contributing to the solution will go a long way to finding a better way to administer health care in the United States. Reward those that are finding solutions and penalize those contributing to the problem.


HEALTH CARE COSTS
BLISSFIELD MFG CO.
$ THOUSANDS $
6
5
4
3
2
1
0
68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92
YEAR
COST
PER EMPLOYEE PER YEAR

Mr. Dingell. The committee thanks you. We know you have come a considerable distance.

We also know that you and your company are struggling to maintain health benefits for your employees. We know how difficult it is. The communications with staff have indicated to us not only the difficulty with which you are confronted but the vigorous way in which you are addressing a difficult problem.

The Chair is going to recognize my colleague, first. Mr. Schaefer.

Mr. Schaefer. I thank the Chair, and I appreciate the opportunity to get your views on this.

I think this certainly ties into everything. I am going to direct my questions more to you, Mr. Farver, and my colleague, because of time limits here.

We know we have a disadvantage when it comes to the Japanese in the way that they handle their health care costs and the costs of their automobiles. Sandy mentioned a few minutes ago that it was something like a $1,000 per car, depending on the type of car it is. But you previously described that there is an automatic 131 percent of health care cost penalty for American companies competing with Japanese firms. Can you elaborate on this?

Mr. Maher. Yes. There is an exhibit to my statement, Congressman Schaefer, that gives you the source of that. What that is is based on the per-capita spending on health care in the United States, all payers versus per-capita spending on health care in Japan. The OECD publishes that data for all countries in the world. And that information was the source of the information regarding the comparison with Germany and Canada, et cetera. It is per-capita health spending. Take all the dollars in the Nation that are spent on health, divided by the number of people.

Mr. Schaefer. While Congress is translating the dollars and cents, could you possibly make an automobile?

Mr. Maher. I think as you heard, in fact, Congressman Upton was at a hearing where a member of the faculty of the University of Michigan submitted some testimony to the Energy and Commerce Committee earlier this month. And on a blend of—it was actually not just the United States, it was the United States and Canada, the total health cost component of a North American-built car, from the Big Three, was about $1,086.

Mr. Schaefer. My colleague was right on the nose, then.

Mr. Maher. That was a University of Michigan study, but they were working off of data they got from General Motors, Ford, Chrysler and many parts manufacturers in this country. And including United States and Canada.

Mr. Schaefer. Let me ask you the question, taking into consideration that and the benefits our American workers——

Mr. Maher. By the way, excuse me, I would like to make it clear, that was 1990 data. So it is probably worse today.

Mr. Schaefer. You have got to creep up on this microphone—these Japanese microphones. Just because I am from Colorado doesn't mean you have to give me the bad mike. You didn't deduct that from my 5 minutes, Mr. Chairman?

Mr. Dingell. No, I did not.

Mr. Schaefer. What was my question?

All right. In comparison to the quality of care that our American workers get from your plan, do you have any idea how this would compare with the quality of care the Japanese get?

Mr. MAHER. No. And I think the quality issue is a very important issue, because it may be that we don't like the Japanese health care system, that we would want to improve upon it. But the policymakers, yourselves, that is at least something that has to be taken into consideration in a global economy.

I heard the question of the last panel. I was involved for 12 years, sitting on the other side of the table from these gentlemen, both in the United States and Canada, and I never experienced a situation where in Windsor the employees of our Canadian operations wanted to waive their coverage and opt for Blue Cross/Blue Shield. That was never a demand we faced.

Not that the Canadian system is the best system. I, frankly, don't think it is. But the fact is that nowhere in the world are people trying to copy our system. And they are doing some things right around the world. And we shouldn't try to copy anybody's system, but we should scour the globe and try to pick what is best and incorporate it in our system and try to be the best in this country, for quality and cost.

Mr. SCHAEFER. I always look at the Canadian system—we are talking about fewer people in Canada versus the United States, and just incorporating the whole doesn't mean it would totally work. I am sure parts or portions of it will.

Let me ask you, what has Chrysler been doing to try to control the health costs in managing the care of their employees?

Mr. MAHER. I would like to think, Congressman Schaefer, that we have probably been as active if not more active than any company in the United States. We were the first company to have a board of director's level committee addressing the subject, by including both the Chairman of the Board of our company and the President of the UAW sitting together on this subject. We have well over 50 percent of our employees enrolled in HMO's, PPO's, exclusive provider networks. We have kept our rate of cost escalation at around 8 percent for the last 10 years or so, well better than business in general. I have got to tell you, we have got a very unuser friendly health plan. Our people have to jump through lots of hoops to get services.

But we have found that if that is all we do, we are not going to control our health costs. Because for every dollar we may save, we may get $1.25 shifted to us as a result of our fragmented system. So we have to develop some common game plan in this country, everybody pulling in the same direction, maintaining the same objectives of maintaining quality, but making our country the best in terms of efficiency and quality.

Mr. SCHAEFER. Last April in Colorado I held a health care fair at which I had hospitals, doctors, businesses, everybody that has anything to do with health care, and there was an interesting comment made by Bill Coors, the President of Coors Brewery, located there in Colorado. He said that they were contemplating—and they have a wellness center—they were contemplating saying to their employees, if you go through this wellness center, you are tested for your blood pressure and your cholesterol and everything, and you have a problem, you start working on it, and we will pick up the total health care costs. If you don't do that and you don't show an improvement, then the health care cost starts to be reduced by the company and has to be paid by the employee.

Is this a possibility? Is this being done anywhere?

Mr. Maher. We have similar arrangements for a lot of our employees in the United States. We are a big believer in prevention, in screening, in education for employees. And that is a very important element of an overall policy for this country and for any individual business.

But like a lot of things, like tort reform, it is not the only thing. But it is a very important thing that has to be addressed.

Mr. Schaefer. So, in other words, you think maybe this could be built into an eventual solution?

Mr. Maher. Yes, I do. But I have got to tell you that going down that path is filled with hazard, because it is easy to pick on some things like smoking and alcohol consumption, but mark my words, you are going to have people come out of the woodwork who tell you, I want to get the joggers and penalize them because of all the damage to knee joints and the health costs they are causing. The skiers who break legs. It will happen. I have heard it.

Mr. Schaefer. We have not only breaking legs but a lot more serious things happen in Colorado.

Mr. Chairman, I yield back.

Mr. Dingell. The gentleman from Michigan, Mr. Upton.

Mr. Upton. Thank you, Mr. Maher. I appreciated your testimony earlier this month, and I certainly look forward to today.

Mr. Farver, believe it or not, I have been in Blissfield, and I have been to your facility, and it is amazing to me to see the costs that you have shown in your testimony, which is about $500 or so back in the early 1970's per employee. It is almost $6,000 today.

What is the average cost per employee that Chrysler pays per employee for a year? It is not even in the neighborhood of $6,000.

Mr. Maher. Well, for older workers, Congressman Upton, with a family, it certainly could approach that. The cost——

Mr. Upton. But that will be the average cost. Some will approach that.

Mr. Maher. But I am not sure what the average age of your workforce is. But if you happen to have a workforce that has an above-average age, and you may be an incredibly fine company in doing what you do, under the U.S. health system, if you are competing with someone, the luck of the draw, has a younger workforce, that person has an advantage over you. You don't have that in foreign countries.

That is one of these policy issues that I think has to be considered, is that of proper line of demarcation in competition, the age of a workforce. Are you going to penalize one versus the other?

But you could pay $6,000 for a family for coverage.

Mr. Upton. Is that one of the reasons you have gone up, because you have been such a good stable business in Blissfield for 46 years?

Mr. Farver. As I mentioned, we do have many employees that have been with the company 45, 46 years. It is not uncommon to have 2 and 3 generations working in our company, and they stayed a long time. We have had a lot of retirees in the last 5 years. The workforce is shifting and changing to a younger workforce. The average is probably 45 years old at this point, whereas maybe 5, 10 years ago, it was 50, 55 years old.

But also I think our benefits are far superior to most. On the union side, it is still first dollar coverage, full hospitalization, optical, dental, prescription. We take good care of our people.

Mr. UPTON. Is your specific plan—do you have a small group health insurance plan or something in that neighborhood, looking for a specific break?

Mr. FARVER. We have two specific plans. Up until around 5 years ago we were all under the same plan, total hospitalization. Because of costs, we had to go to an 80–20 situation for our salaried workforce. So now we have two distinct plans. For cost savings reasons. And we are always looking to reduce those costs.

We just went through an exercise, in fact we just wrapped it up last week, looking at another provider, with some substantial savings, but unfortunately their numbers went 1 to 99. After 99, you wouldn't qualify for the plan. Being that we had more than that, we could not qualify for the plan. We asked them to look at two specific groups, the retirees as well as the working employees, if they would consider two plans. They wouldn't touch it.

So we are constantly looking to reduce costs. We are making our employees aware of what costs they have used on a monthly basis so they can be aware of it and try to curb abuses.

Mr. UPTON. You have a number of facilities, as I recall, around the country, is that right?

Mr. FARVER. We have three facilities active right now, one in Michigan, two in Indiana. The third in Indiana we closed 2 years ago and moved back to Michigan, which is a twist for most. Usually it is going the other way.

Mr. UPTON. Have you noticed between States a large difference or any difference between—your graph, I expect, is for all employees?

Mr. FARVER. That is correct. That is an average. It could be less depending on single coverage. Obviously, family coverage can run as high as $60 a month. This is an average. So it could be higher or lower.

Mr. UPTON. I appreciate your attendance this morning. Thank you.

I yield back.

Mr. DINGELL. The Chair thanks the gentleman.

The gentleman from Michigan, Mr. Levin?

Mr. LEVIN. Well, Mr. Maher, I had a chance to be on the plane this morning, so I don't need to burden you with any questions.

I do think it is a good idea that we hear from a mix of the business community, Mr. Chairman, as you are doing. And as we look at this issue, we look at the needs of smaller business as well as larger, so that we don't end up providing an answer that simply shifts the cost from larger business to smaller business. That isn't going to accomplish very much, if anything. In fact, it may set us back. So I think the two of you, in a sense, represent the challenge.

Thank you very much.

Mr. DINGELL. Gentlemen, the Chair once again thanks you for your helpful assistance. Mr. Schaefer?

Mr. SCHAEFER. If you will permit me, Mr. Chairman, I would like to ask one other question of Mr. Maher.

I think the facts show that in other industries throughout the country, the growth rate is approximately 14 percent. Yours is only 8. That is interesting. What are you doing different?

Mr. MAHER. Well, as I mentioned, Congressman Schaefer, I honestly believe we have been at this a lot longer——

Mr. SCHAEFER. You recognize the problem?

Mr. MAHER [continuing]. Than other companies, because it has been a big problem, and also we had a major management change in our company in the late 1970's. We had the opportunity at that time to literally scour the operations. In looking for pockets of problems, this one obviously jumped into very clear visibility. And have been working on it ever since.

Mr. SCHAEFER. You were one of the pioneers, in other words, in recognizing this, and I applaud you for that. Thank you.

Mr. DINGELL. Gentlemen, I am curious. We have many different reform plans suggested to repair our system. One is to continue the current plan. One is to shift to essentially a pay-or-play plan, in which the employer either offers a given level of benefits or pays a given level of taxes to provide those services. Or we have a national health insurance plan with a single payer. That single payer could have his mechanism of providing services in an array of different fashions.

With regard to the manner in which the country should address this problem, what is your preference with regard to the mechanism of payment? Should we pay by payroll tax? Should we pay by some other mechanism? Should we pay from general revenues? Should we have a specific dedicated tax, a value added tax, or something of that kind to pay for the costs of these kinds of services?

Gentlemen, I am not asking you to speak on behalf of your company, but just indicate your personal preference. If you can or desire to, express the views of your companies.

Mr. MAHER. Mr. Chairman, we testified on several occasions that, rather than picking out any particular plan, we think we have to set up the objectives of what you want a health system to provide. Those objectives, we believe, should be: (1) coverage for all citizens; (2) a process to control cost, clear process to control cost; (3) a process to assure that the cost of the system is spread equitably across the economy so that you don't burden inappropriately any particular sector; and (4) that you operate in a context of continuous quality improvement.

Then you say, all right, how do you accomplish this? How do you finance it? And we see as a company 1 of 2 ways of proceeding. Both of them would have the common ingredients of having health care delivery, private-sector oriented, competitive, pluralistic delivery systems.

But in terms of financing them, you could finance them either by building on the current employer base model, with public coverage available for the poor and the elderly, with employers being required—having two choices, one to offer health coverage to people, or two, in lieu of that, pay some type of a payroll tax so that they are contributing in some way to the financing of health care, thereby enabling people to enroll in some tax-financed system.

But both the public and private sectors operating pursuant to the common rules, with a budget established for the system, with fees determined hopefully through some multilateral way and not dictated from Washington. But, once those fees are determined, have them binding on both the public and private sector to avoid cost shifting.

The other method of financing would be to finance it through the tax system. And I want to emphasize there is a huge difference between having a tax-financed program and a government-run program. For example, the Federal Employees Health Benefit Plan was ironically just written up by Stewart Butler of the Heritage Foundation as a model plan, as an example of how you can have competition among plans, and that is fully tax financed.

Mr. DINGELL. It also goes up at a high rate of speed every year.

Mr. MAHER. That is because there is no overall process to control costs. So my only point is that you can have a tax-financed plan with lots of choices. I could make an argument that, for example, for years one of the problems with the Medicare program and a problem with the Canadian health care system is that it is replete with choice. You have unfettered choice.

And so the irony is that we hear a lot of discussion now about organized systems of care and coordinated care, all things that make a lot of sense in my company's view, but, by the way, the only way they work is constraining choice. And that is not all bad. It is not necessary to pick your doctor out of the yellow pages.

We think we can support either type of system, either a tax-financed system or one that is built on the employer-based model action as long as they met those common objectives of cost control, universal access and quality.

In terms of if you had a tax-financed system, you say, what is the best tax? There are obviously many ways to do this.

Mr. DINGELL. What is the best one from the standpoint of competitiveness?

Mr. MAHER. My company has long supported some form of either a business transfer tax or a variant of a value-added tax because of its ability to disperse costs through the economy. When you consider that the current health—you know, a lot of people say, wait a minute, that impacts prices. The current health care system is largely financed by employers, and if anyone doesn't think that is almost the same thing as a sales tax, they are not a student of this issue. Businesses, one of the ways they recover their costs is to add to prices. And that is the same thing as a sales tax.

My sense is that it may not be appropriate to rely exclusively on one single tax vehicle. But that is one that my company is supporting. We are also a member of the National Leadership Coalition for Health Care Reform, which has supported a comprehensive health reform strategy, but one which, for people in the workplace, builds on what you characterize as a pay-or-play model. That obviously relies to a certain extent on payroll taxes as a way of financing health care.

And again, that is, in fact, how a lot of health care is financed in the country today. Because, to the extent that an employer buys health insurance, that clearly is part of an overall compensation package and in essence functions somewhat like a payroll tax. I will just stop there.

Mr. DINGELL. Mr. Farver, what are your comments, please?

Mr. FARVER. I would agree with Mr. Maher on the majority of his points. I don't think it is one perfect system, obviously. I think a lot of focus needs to be put on the prevention and maintenance of health care early on so we don't get these people into the system early on in years so it becomes costly.

Also, I feel that right now the system is really not fair and equitable. Certain people paying, as was given earlier by our gentleman from UAW, I believe, people that are paying health care costs end up paying a premium for those that can't pay, doctors charge more, et cetera.

I think we need to establish clear goals, levels of service and also cost controls. Like any business, we are required every year to reduce our cost from continuous improvement efforts. I don't think you are seeing that in the health care system. It is a situation where the costs keep escalating, and nobody is doing anything about it. You have no control over that. You have to go to the doctor. You have to go. You have to pay.

It needs to be a more competitive situation. That is where maybe the public and private partnerships can be formed.

It may even be better to go to more localized. Every community I know has different needs and different requirements. Maybe through local networks.

I am not an expert on this by any means, so these are strictly opinions, but I know in our community we do have good health care in the community. If we can get into a preventive mode and get a fair cost throughout the community, so that everybody pays their fair share, businesses pay their fair share—I think businesses are overtaxed already as a small business owner, so I don't know that that is really the way to go.

Mr. DINGELL. You just raised a point, the fact that business is overtaxed, and the payroll tax system is one which is particularly repressive to business from the standpoint of dealing with exports and foreign competitors, or dealing with importers. Obviously the union management agreements are becoming extremely costly and obviously impacting the competitiveness of American firms.

The question is then whether something like a broad-based tax like a value-added tax is going to be the mechanism that would deal with our competitive problems compared to foreign competition and put us in a better position? We are spending $1,000 a car and more.

Mr. MAHER. Mr. Chairman, as I indicated, my company is very sympathetic to value-added type taxes. But I must add that at least our major competitors in Germany and Japan are the major financers of their country's health care cost, and they happen to finance it through a payroll tax system. They have the advantage, however, of having those costs be infinitely less than our cost. And I also don't know, maybe—I am not sure of this at all—whether any of those taxes are rebated for exports. I don't believe they are.

I wanted—if I could to sort of reemphasize the point regarding the difference between government run and tax financed, because this issue is unfortunately getting too politicized for the importance that it has to the country. And there is a lot of discussion about equating a tax finance with some monolith government program.

Notwithstanding the fact, and it is ironical, that the Medicare program which has a lot of problems still is very popular—and I doubt there is a lot of people who would introduce bills to repeal the Medicare program because they found out it was tax financed—but you can have——

I mean, Senator Kerry, for example, has introduced his bill, one of the several, and while it would have a tax-financed health care system, it would, in essence, get the Government out of running it. It would use the Government solely to collect money and then distribute it and have health care delivery as we have today through private-sector-oriented delivery systems, all of which had to compete in each State with one publicly run plan. It would be one public plan in each State. Then everyone else would be eligible to receive the same payments that the public plan would, and they would compete.

So if the concern here is that we want to have more competition in the delivery system, you can have that in a tax-financed system. The Medicare program could be transferred to that—transformed to that type of a system.

So we should put our emphasis first on what do we want? What is the architecture of this product that has to cover everybody? It absolutely must have the capacity to control cost, and it has to have some structure to assure that you don't save your costs through skimping on quality.

Mr. DINGELL. Mr. Farver, what are your comments?

Mr. FARVER. I agree. Quality is the main issue here, and the cost controls, as I said earlier. It is like any business. You have to remain competitive. And if you don't have any controls to keep costs from going up, they will continue to go up.

So I really don't have a lot of comment on it. I really need to think more on the subject. It is pretty far-reaching.

Mr. DINGELL. Mr. Maher, you served with considerable distinction as the co-chairman of the Governor's Task Force on Health Care. That was created because of the concern of over a million Michigan residents without insurance. The Task Force warned that the problems would get more difficult in the 1990's. It is now 1½ years since the Task Force presented the Governor with its conclusions. Can you cite any progress that has been made with regard to either implementing those recommendations or reducing or eliminating the problems the Task Force identified?

Mr. MAHER. Mr. Chairman, I think there has been some progress in terms of—one of the recommendations of the Task Force was to develop some grassroots support for the recommendations of the Task Force for purposes of any legislation that might be required. I know that through the offices of Michigan State University, that type of grassroots support building is underway.

However, meeting the health care needs of the unfortunate in this State is largely dependent on the economy of the State. And since the—that Task Force concluded its business, the economy of the State of Michigan has not fared too well, to say the least, which has made it very difficult to accomplish these objectives.

From the standpoint of the business community's participation in that Task Force, one of our concerns was the cost-shifting issue that I mentioned during my remarks. And, unfortunately, that cost-shifting issue is continuing to exacerbate as more and more of the general assistance people here in Michigan lose their eligibility for health care coverage.

That does not immunize them from illness. They still get ill. When they get sick enough, they get treated in a hospital, and those costs get passed on to private payers.

So my company is continuing to work—even though the Task Force is no longer in business, I stay in touch with the people at Michigan State University and try to do whatever I can to continue to build grassroots efforts here.

Mr. Dingell. Mr. Farver, do you have any comments?

Mr. Farver. No. I think on the overall issue, as long as we can provide a plan which is fair and equal to everyone, and ultimately gives everyone health care—I think it is sad when people work all their life, they retire, and their pension doesn't even cover their health care premiums. And the worry of whether they are going to be able to pay their health bills is enough to make them sick. I think it is a sad state of affairs when people work their whole life to retire to a better way of living, and it is gone because of health care costs.

I would be in favor of funding that type of program, as long as there is some relief to the business, and that we can plan and know what our costs will be. If we know what the costs will be, at least we can plan and budget for them and try to remain competitive that way. The way it is now, we have no idea what it is going to be this year, next year or in the future. And it is hard to run a business that way.

Mr. Dingell. Mr. Schaefer, do you have a question of Mr. Maher?

Mr. Schaefer. Yes. Both Mr. Maher and Mr. Farver.

Looking at the graph you presented, that health care costs are going up, it seems to create a situation between small business and big business where people like Chrysler, who have more employees and are better able to negotiate with insurance companies due to the numbers, could help hold those costs down. Whereas the small business—and I came out of the small business world so I understand many of the problems you face, you have to individually, with—how many employees do you have?

Mr. Farver. 250.

Mr. Schaefer. Still considered a small business—but you have to negotiate individually with a carrier.

Mr. Farver. That is correct.

Mr. Schaefer. Therefore, you do not have the power, so to speak, and therefore your rates may be not comparable. And, in many cases—I am not saying this to you two gentlemen—but in many cases the large business blames the small business for rising health care costs, and the small business says, well, big business, you get the better deal than I get out there.

From your perspective, the organizations like NFIB or an insurance pool which would buy collectively, is this possible today, or is it an idea that you could——

Mr. Farver. I think it is a very viable option that communities pool together, possibly, to try to bring those rates down. At least it will keep them under control.

In our county we have a number of small manufacturing and family-owned businesses, and I know every one of those has different problems, and they are all facing the same thing, and they are all networking and pulling together. That is one very viable way to address the problem.

Mr. Schaefer. I know back in 1984 or 1985, somewhere in there, we had this unavailability of insurance for municipalities, fire departments. We were all having tremendous problems on how to insure ourselves. And therefore the insurance pools were created.

The difference I see in your business is that you are manufacturing widgets, and somebody else is manufacturing some other commodity, and the danger point of somebody getting ill in one business may be different than the other. Therefore, that would create a tremendous problem, or you are not talking about CPA's as a whole or municipalities as a whole. Is there a way of working around this if we think about this type of thing?

Mr. Farver. I think there is always a way if there is the will, obviously. But no, it needs to be studied.

I understand what you are saying, the chemical industry versus, let's say, say small manufacturing industry. There are different things that can cause problems. But I would think you would need to look at what the experience rate has been at each one of those industries, put those together, run the numbers, average them out, and see what was what.

To try and get an insurance carrier to do that would be another thing. Maybe the answer is communities start their own insurance companies, their own groups to administer the plan on a local basis. Put the power back to the local people to administer, and also then they would have control over their experience.

Mr. Maher. Congressman Schaefer, on that point, one of the things—and I don't have the data here in terms of—one of the reasons that our number was 8 percent is that it reflects a certain amount of cost shifting to employees and retirees. That tends to impact that number.

The COSE group in Cleveland, that is a very good coalition of small employers—coalition for something, COSE. I have heard them as low as 10½ percent. I have heard 1 percent say 15. But let's say it is 10½ percent. The point to remember, though, is that is still 2 to 3 times CPI, growth in the economy.

And to the extent that we, starting where we are, already so much more expensive than the rest of the world, and continue ourselves to let health care grow at two to three times the rate in the economy, what that is doing is slowly absorbing the resource of this Nation, reallocating them to other needs, when there is already a consensus today, whether it is from Dick Darman to the most liberal guy around, saying, we are spending too much. We have got to figure a way. There is no reason in the world why a Nation as wise as this one is has to spend 43 percent more per capita than the second most expensive country on earth to meet our Nation's health needs.

We have got the smarts to do it for less than what we are spending now. So we should not get ourselves hooked on a system that aggregates or, again, bet the farm on aggregating small businesses so they can improve their lot in life to the lot of larger business, most of whom are griping about health cost.

So this is a broader problem. All of these things make sense, but they all have to be incorporated in a much more comprehensive strategy to meet the macro objectives.

Mr. SCHAEFER. One last question, Mr. Maher, and a follow-up on the chairman's initial question. The Task Force that you were on created by Governor Milliken and continued by Governor Blanchard——

Mr. MAHER. Governor Blanchard started it.

Mr. SCHAEFER. Anyway, are other States doing this type of thing? And were some of the answers you pulled out here about a crisis in the State of Michigan, should these be repeated in other States? Just a comment on that.

Mr. MAHER. There have been a number of initiatives, Congressman Schaefer, in many States. In fact, I have attended meetings where the States get together to pool their ideas. The League of National Governors Association has taken an active interest in this.

And while on the one hand I am a big believer in local initiatives, as an employer, with operations in all States, I shudder to think that we will have 50—not to mention maybe northern California to something different in southern California—different strategies. That would be very, very complex.

That is not to say that there can't be variations between some sort of master plan with variants but all sort of generally pulling in the same objective. We don't need a cookie cutter.

Mr. SCHAEFER. Are you finding the Michigan problems are repeated in Mississippi or Kansas? Are we coming down to the same basic problem?

Mr. MAHER. Yes. First, everybody—sort of the core problem, everybody confronts the cost problem. Some States are more fortunate than others. Some States have tradition. This State has a tradition, I think, more of a caring tradition. We have a lower overall uninsured rate in this State than our surrounding States.

It is the best of a bad lot, let's say. This is not—on one end it is complex, but it is not complex. We don't have a process to control costs, and therefore we shouldn't be surprised that all 50 States, notwithstanding the fact they have got a lot of smart people in them, can't control them.

Mr. SCHAEFER. Some of the more rural States have a problem.

Mr. MAHER. Right. I contrast this with defense. We are spending 5 percent of our GNP on defense; Germany, 2 percent; Japan, 1 percent. Citizens around the country look around the world. They know their tax dollars support defense. They want real reductions in defense spending.

Obviously, there is local pockets of interest, understandably. I don't want my base closed, whatever. Citizens want real defense spending, and they are going to get it.

Contrast that with health care. You look around the world. We are 43 percent more than the second most expensive; 14 percent of our GNP versus 6 in Japan and 8 in Germany. People, the consensus is, want lower cost. Can't do it.

Mr. SCHAEFER. It comes down to cost or quality.

Mr. MAHER. But it tells you something that in defense at least there is a process to get it done. In health care, notwithstanding the will of the citizens, it can't get done. That tells you you need to develop a process.

Mr. SCHAEFER. Thank you, sir.

Mr. DINGELL. Mr. Farver, I was looking at the chart you submitted to us. In 1968, Blissfield spent about $400 or $500 per employee for health care. Today in 1992, you are projecting your cost just short of $6,000 per employee. That is about $5,500 more. Is that right?

Mr. FARVER. That is correct.

Mr. DINGELL. Do you have any projection as to the future level of cost increases?

Mr. FARVER. If they are as they have been historically in the last 10 years, we will look at 10 to 15 percent per year. We will stay in business, whatever it takes. Once again, it puts the burden on the employee more so than the employer.

Mr. DINGELL. I visited the farmers, and as I traveled around talking to them, one of the things they always brought out is the latest Blue Cross bill. Do you have in Blissfield an insurance plan?

Mr. FARVER. We buy the insurance plan. We are self-insured on Workmen's Comp.

Mr. DINGELL. Mr. Maher, ,you are essentially self-insured at Chrysler?

Mr. MAHER. Yes.

Mr. DINGELL. You use folks like Blue Cross to provide the administrative services, is that right?

Mr. MAHER. Yes.

Mr. DINGELL. I guess, gentlemen—I note that the United States has some—some 1,100—1,500 different health care plans. I was over in Canada talking to people at Canadian hospitals, and I was in this country talking to U.S. hospital people.

One day we visited six, four in the United States, two in Canada. We asked the U.S. hospitals how many people they had in their billing offices to deal with billing. They said 50 to 60.

We asked the Canadian hospitals of identical size, 600 beds, how many they had dealing with billing. They said, "We have between three and four." Are there efficiencies that can be achieved by reducing the number of plans with which we are blessed or cursed in this country?

Mr. MAHER. No question about it, Mr. Chairman. The physicians of this country very properly talk about what they call the hassle factor, and it is not only a large number of insurance companies, it is the fact they all have their own different rules.

My company, for example, has lots of different rules that we think make sense to help control costs, but it generates another rule book that thousands of doctors in southeastern Michigan have to have. It complicates the back-offs of doctors, of hospitals.

Some physicians, understandably, find it intrudes in their ability to minister the health needs of patients. Not that sound cost control is not important, but it would be better if—again, there it was more coordinated, so the physicians and hospitals in this country could spend the great bulk of their resources meeting health care needs of people rather than jumping through hoops by all kinds of thousands of different payers.

Mr. DINGELL. Those hoops are expensive, are they not? All the different rules they have to meet and all the different folks they have filling out forms and all the different forms they have to fill out for all the different people are enormously costly and wasteful, are they not?

Mr. MAHER. You are correct. I am pleased to say there appears to be some bipartisan understanding of that issue and work to try to address it. But it is a huge problem, and I can understand and sympathize with the physicians and hospitals in this country when they make the fuss they do about the hassle factor.

Mr. DINGELL. The ordinary citizens have to confront it, and the people who pay the bills have to pay the cost of all these people that contribute nothing.

Mr. MAHER. Mr. Chairman, it is too bad what happened to catastrophic, because all Congress and the President have to do is look at the Medicare program. If you were going to get out a clean piece of paper and write a health policy for the elderly of this country, I don't think you would write it with the thought in mind that any person with my means would have to go out and buy another insurance policy to cover what your plan didn't cover, and that is what the seniors of this country have to do.

That adds complexity for them, for their doctors, for their hospitals; confusion for family members that work with older parents in filling out forms, and deciding who gets what bill. That is a classic example.

Mr. DINGELL. Well, this committee, as both Mr. Schaefer and Mr. Upton can testify, has been very active in looking at fraud, waste, abuse and mismanagement in the so-called supplemental plans that we have for senior citizens. And the Congress adopted protections as a result of this subcommittee's activities.

Gentlemen, you have been here for a long time. We thank you both for your assistance. We appreciate it. We thank you, both gentlemen, for your assistance.

The Chair announces our next witness will be Representative David Hollister. David Hollister is the chairman of the Appropriations Subcommittee that deals with matters in the Michigan House, is an expert who has appeared before this subcommittee on a number of occasions. His testimony has always been invaluable and informative.

Representative Hollister, if you will come forward we will be delighted to receive your testimony and hear your comments. Thank you for being with us. Would you like to identify your associate?

STATEMENT OF HON. DAVID HOLLISTER, A STATE REPRESENTATIVE FROM MICHIGAN, ACCOMPANIED BY WARREN GREGORY, PROFESSOR, HOUSE FISCAL AGENCY, MI.

Mr. Hollister. Thank you, Congressman. I am Representative David Hollister from Lansing, I have served in the legislature 18 years. I chaired the Appropriations Committee on Social Services for the last 14 years, so I am kind of a masochist.

I have responsibility for the Medicaid budget. I am on the mental health budget, public health budget and the school aid budget, so I kind of see the interrelationship between those budgets.

I chair a special committee on the legislature of State, local and Federal Government, trying to see the interaction between Federal policy, State policy and local government. It is in that context I come before you this morning.

I am joined by Warren Gregory, a professor on the staff of the House Fiscal Agency, and has done a lot of research in this area. I forgot to fax to you a recent study done by Steven Gold. Steven Gold is with the Center for Study of the States out of Albany, New York, and he just published a report called "The States and the Poor", where he tries to do an analysis on what is going on across the country in all the States, not just in Michigan. I have a summary of that I can leave with you. I highly recommend the summary.

Basically, what he tries to do is summarize why all the States are in trouble, not just one. You can't go to Michigan and say we have a bad Governor or legislature. What he talks about is basically the States are facing two problems:

The first problem is a prolonged recession. When the Nation is in a recession, Michigan suffers dramatically. While the country is in a prolonged recession, there is another thing going on that is more important but less understood. That is, there is a substantial change in our structural society. Those structural changes are having a bigger impact than the recession. Even when the recession is over, Michigan is not going to bounce back. Ohio is not going to bounce back, Illinois is not going to bounce back.

Let me just highlight for you, if I could, the five structural things that goal talks about, because they are very essential to what you are looking at. The first thing is obvious to all of us in all the States, is the cost of health care. And you are focusing on the growth of Medicaid and Medicaid over the last decade, since 1980 in Michigan has gone up about 128 percent, so indeed it is one of the fastest growing parts of the budget.

And we just had our presentation last week that Medicaid is now 53 percent of Michigan's social services budget. Ten years ago it was 33 percent. So, when you are talking about more money going to the poor in Michigan, it is going to the physicians of the poor, clinics of the poor. It is not going to the poor. It is going for health care, and the grant levels have not kept up, they have been going down.

So, while Medicaid has been going up 128 percent, we need to look at other parts of our budget where we spend money on health care. Medicaid has gone up 128 percent, but if we look at State employee health care costs that we pay for with our tax dollars in the same decade, those costs have gone up 269 percent, almost double. So we are paying double for health care growth of our State employees.

If you look at our State retiree costs that we also pay out of our State dollars over the same period of time, since 1980, those costs have gone up 647 percent. If you look at our teachers, we help finance the teachers' health care costs and their social security and retirement. That has gone up 800 percent, Congressmen.

Corrections: When we put a person in prison. If we put them in prison, we pay four times more and our prison health care costs have gone up 403 percent. If you put those costs together, Medicaid, State employees, the teachers, the prisons.

Mr. CONYERS. Are those correction officials or inmates?

Mr. HOLLISTER. Inmates. The correction officials are paid for by State employees. If you put all those together, you have gone from 20 percent of our budget to 26.7 percent. The pie is being squeezed by health care. And that is true in all the States, not just Michigan. So keep that in mind.

Medicaid is a pauper. Let me say that again, Medicaid is a pauper compared to the other costs of health care. So that is the first thing confronting all the States.

The second thing is the changing role of the Federal Government. When I came into government 20 years ago, we considered the Feds a partner and you considered the States a partner, and we considered the counties a partner, and we were all in partnership trying to fix things.

Now that has changed. Now we are seen as the enemy. The States see the Federal Government as part of the problem. Now we are no longer seen as partners; we are all seen as bandits in this, seeing who can shaft who. There has been a policy of what I call the shift and the shaft.

The Feds are shifting responsibilities to the States and cutting us. We try to maintain it as long as we can, and now we are cutting responsibility and shifting it to local government. If you don't think that is happening, wander up and down the streets of Detroit.

What that means to Michigan is—this is true of all the States—we have lost an amount equal to our entire State budget in Federal budget cuts in the last decade. For Michigan, that is $11 billion in cuts. Our entire State budget is $7.6 billion and we have lost $11 billion in budget cuts. Congressmen, those cuts are in employment training, they are in urban development, they are in education, they cut across the board. We have seen a changing role in the Federal Government.

While the government is cutting back payments to government, and most of those cuts, by the way, were in State and local aid, they have been mandating new programs, and I have been the biggest supporter of the mandates.

Frankly, if it was not for the Federal mandates, Michigan would not be expanding health care. What we have been seeing, a very subtle decision to create universal health care for children. We have been expanding access to women and children, which I believe in.

At the same time, we have ended health care for 85,000 adults in this State. So we are kind of singling out one group to get universal health care for children, and I have supported that and we have done it through your mandates. At the same time, because of the budget constraints I just talked about, we had to cut back in other areas.

One of the key questions we have to deal with as State legislatures is health care. I think there is a consensus that health care is a right. The next question is, how do we organize it and pay for it?

This problem of the changing role of the Federal Government from partner to, now, the perceived enemy is fundamental to our problem. I am here to support the mandates. You will have others criticize you, but I am not one of them. We have to provide universality, and now we are doing it for the children, but we have to do it for all.

The third thing that is happening to the States, the economy is changing in Michigan and it is changing throughout the country. Michigan lost 30 percent of its manufacturing jobs, and 80 percent of those manufacturing jobs had health care.

We have been creating service jobs and our service jobs are up by 33 percent in Michigan; we have created over 400,000 new service jobs at the same time we were losing those manufacturing jobs. Unfortunately, most of them have no insurance.

Sixty percent of the new jobs in Michigan, Congressmen, pay $7,000 a year or less. Sixty percent of new jobs in Michigan pay $7,000 a year or less, and most have no insurance.

You have got a new phenomenon in this country and it is going on all over. You can have an intact family, husband and wife working full-time at a minimum wage job and living below the poverty level. What happened to the American dream? And they have got no insurance, and if one of the kids needs a tonsillectomy or any kind of health care, the family is wiped out, they are right on the edge.

So we—and this is happening in all the States, not just Michigan. This new service industry, low-paying minimum wage jobs, no insurance. That is what has created 35 million Americans out there, the working poor, who have no insurance, and you can't blame the small business people because they can't afford to provide it.

Therefore we sit with this new working poor, at-risk family, trying to maintain the American dream and working full time at a minimum wage job and falling deeper and deeper in debt. Congressman you had a question, I think?

Mr. Conyers. No. I have a number of questions. I wanted to wait until you conclude.

Mr. Hollister. I have two other things that are happening to all the States. It kind of helps understand why we are where we are. The next thing is a decision in the early eighties to get tough on crime. We decided not to get smart on crime, but tough on crime.

We started building one new prison 8 weeks ago. In fact, we have been opening them so fast we cannot afford to hire people and train them so we have three sitting vacant. We had to hire prison guards to keep people from breaking into our prisons. That happened right here in this community. We know who are in prison, they are our urban poor, uneducated.

I was recently meeting with some health care people. They said the number one predictor of people in prison, look at their dental charts. They are all without dental care. It is just a symbol, just shows you what happens. Prisons have gone from 2 percent of our budget in 1980 to, 1992, it is 9 percent of our budget, 9 percent.

Congressmen, recently, our director of our local homeless shelter began advising our homeless people if they needed health care, to go get arrested in Lansing. If you need health care, go throw a brick through a window, get arrested. Otherwise, there is no health care available in this State. That is happening in all the States, and we need to get smart on crime.

There are other ways to deal with this. The last thing that is happening in all the States is the growth of tax expenditures. This is the second fastest growing part of State budgets, tax loopholes, uncollected taxes. And we deal with them all the time. They are popular to do. Give this group a break. They are all good ideas, but they are eroding our tax base at the very time we are having more and more demands on health care. This is happening to all the States.

So, you have got two things. States are dealing with a prolonged recession and a structural problem. Now, that forces them to either cut back or to raise revenues and Gold's analysis talks about how the States have cut back. Michigan is one of a couple of States to try to solve the entire problem by cuts. Even the States that raised revenues, raised taxes, raised taxes in a regressive way so the taxes that were raised hurt the poor the most.

Now, because we have been in a cutback strategy for 10 years, we have not been able to reinvest in our infrastructure. This became obvious to me when I drove in from Lansing.

I drive a little compact car. I almost lost it driving on the expressway because of the potholes. We haven't been investing in our infrastructure. We haven't been investing in new campuses. We have been investing in prisons and we have been cutting back everywhere else. We haven't been able to invest in training and employment programs. Now our workers are no longer competitive.

We can't sit here and bash the Japanese, because if Japan owns an American plant, they spend $2,700 more than an American manufacturer in the same plant. They are investing in employment and training, and we haven't been able to do that, and most of the cuts that have come from the Federal Government have been in employment and training.

By the way, the employment and training programs we did have, the Governor vetoed, so we lost the Job Corps, the Youth Corps, Neighborhood Corps, Conservation Corps, all gone. We are in a pickle. I am here to tell you we have to scramble quickly or it is going to be a total disaster.

You asked for recommendations. We need a national health insurance program. We need a single payer and we need it now. That is the most efficient, the most effective, and it has got to be a fairly rapid solution, or you are just not going to do it.

The President's program is hopelessly inadequate. We need a national housing policy. Congressman, I know you are interested in housing. There has been an 80-percent cut in housing support. We need a national family leave policy. We need a national day care policy.

It was interesting, I was recently in a conversation with one of my Republican colleagues and he was talking about how we are overtaxed. I said, well, people are angry. They are angry because they don't get much back for their taxes.

You look at Europe and Japan, people pay a lot more as a percent of their wages in taxes. They get a national transportation system. They can jump on whatever, the subway and travel all over Europe. They get national health insurance. They get day care. They get family leave. There is a sense they get something back.

What we have been doing for the last 10 years is cutting back what little there was so the people are getting angrier and angrier. It is in our own self-interest to find a way to organize these services so middle-class people feel like they have a stake in this government. The government is not the enemy.

If we look at who is beating us around the world, it is those countries where government and business are seen as allies working together to solve these problems. And I am urging you, as I did in Washington recently, to take the lead to bring in these corporate managers, to bring in the small business that create more jobs than the Big Three ever thought of.

Warren said the Big Three will never create a new job in this State again. All we can do is stop the erosion. The people who will create jobs are small business. We need to bring them in and have them participate. We have to see ourselves as collaborators in a joint collective solution, or the Japanese and Germans will beat our brains out as we quietly whimper away.

The situation is desperate. If you don't think it is desperate, walk down the cats border. If you come back safe, you will be lucky.

Congressmen, for the first time, Lansing is an affluent city; Michigan State government, General Motors; and we have families standing on corners, will work for food. It has never happened before. Something is fundamentally wrong, and we he have to respond, and we have to care and show them that somebody cares and somebody is going to offer them hope, or we are in desperate chance of losing it all.

I was in Europe last year, and so excited about the changes that were going on, and they brought every communist government in Europe down without firing a gun because it was a corrupt system and they wanted to be like us. And we can't offer them health care, we can't offer them day care, we can't offer them shelter.

I opened last Sunday's Toronto paper, Toronto Star, condemning what is happening in Michigan. Headline—two page feature—Misery in Michigan. What is going on to our neighbors in the south? Have we lost our soul? Have we lost the sense of who we are and what we are about? That seems to be where we are.

I would close by saying I shared with your staffer a statement issued by the clergy of the State, a group of Bishops came to the Capitol back in December, first time in 18 years that I have been there, and they said, this is morally wrong. You got to stop doing these cuts. You got to offer an alternative. You got to offer people hope. You got to stop playing on prejudice, stereotypes; let's offer people hope.

That is why I traveled down here again this morning, and I will do whatever you asked me to do to try to get this message out that we are losing time and our people are growing impatient. We are seeing it in all the elections. People are angry and they are losing patience. Health care is critical to that, but it is not all of it.

Mr. DINGELL. Thank you, Mr. Hollister.

Mr. Gregory, any comments?

Mr. GREGORY. No, sir.

Mr. DINGELL. Mr. Schaefer.

Mr. SCHAEFER. Thank you. Mr. Hollister, I would tend to agree with you on a number of issues, but we would not agree on others. Small businesses create the jobs. I was sorry to hear of all the manufacturing jobs that you are losing. These are the ones that do carry health insurance where the service jobs do not. I understand that very well.

We have to look at why are we losing manufacturing jobs. I have my own opinion. It goes way back to 1986, when we passed the tax bill, that I did not support for a number of reasons. We got rid of investment tax credits.

When we got rid of investment tax credits, we did not encourage the businesses, particularly small businesses, to go out and buy new machinery, expand their businesses and create more jobs, because we took those tax credits away from them.

I think that is a lot of the reason for what has happened here today, not only in the State of Michigan, but in Colorado, Kansas and many other places. I think tax problems have caused a lot of other problems.

Mr. HOLLISTER. I would take issue to one point. We gave major tax incentives to General Motors, who just left Michigan for Texas. We have gone overboard as a State and local communities.

Mr. SCHAEFER. I am talking about the Federal.

Mr. HOLLISTER. I understand that. What we have to do is target tax policies. One of the things we are advocating if you are going to give tax incentive, let's build in training and retraining. You don't get the tax credit unless you actually create the job and train the person as part of it.

You can bring in all the equipment you want to. If you have to import workers from Europe to run them, or from someplace else, or if you can't hire the staff, people locally to do it, you have got problems.

Mr. SCHAEFER. I understand that. You take any small business, a manufacturing business and you say to them, in order to expand, if you would be willing to expand you are going to create new jobs, which would include carrying the health benefits, et cetera, which we want to see. But in order to do that, we will give you a 7 or 10 percent tax credit on any new manufacturing machinery you bring in.

We combine all this together and, of course, you would have to have a retraining program, or whatever, because you want the local people to get these jobs. I just think that was a big mistake we made, and I think this is reflective of it. I think that issue alone could certainly be beneficial to holding and expanding manufacturing jobs.

Mr. **Hollister**. There was a survey of small businesses in Michigan. Eighty percent report the people they hired lacked the skills to do the job, and they had no money and no training program, where at least the bigger companies had some capacity to do that. It was minimal. It wasn't anything compared to what European and Japanese managers bring with them. Training and retraining is a critical part.

Mr. **Schaefer**. I understand, but that could all be tied in.

Mr. **Hollister**. What I am suggesting, when we do it, be very precise and not give broad ones. We learned very well the broad breaks don't work.

Mr. **Schaefer**. Thank you.

Mr. **Dingell**. The Chair thanks the gentleman. The gentleman from Michigan, Mr. Upton.

Mr. **Upton**. Thank you, Mr. Chairman. I, too, agree that our tax policy is something where we really have to change our emphasis, to blow up the health care system we have today and really begin anew.

One of the concerns I have had, Mr. Hollister, and I don't remember if we discussed it when you appeared before the committee last time, is our joint concern for those 35 million Americans without insurance, 1 million in Michigan, many more certainly uninsured.

The interesting fact I discovered, two-thirds of those uninsured have someone in their family that works. The big companies, Chrysler was here, and a little earlier, the GM's, 92 percent of those firms employing between 50 and 100 people offer health insurance. The small businesses with less than 25 employees, only 42 percent was the number that offered health insurance.

For many of them, it is a matter of fairness. The large companies are able to deduct 100 percent of their costs. The self-employed, particularly farmers in my neck of the woods, the small folks are able to only deduct 25 percent of their health insurance costs.

One of the things I have advocated is to bring that up to 100 percent right off the bat, so we can deal with many of the problems that we have in the private sector with providing adequate health insurance. The question I have for you—it is too bad Vernon Smith is not on the same panel. One of the things he mentions in his testimony is Medicaid expenditures are breaking the bank.

In 1985 here in Michigan, the State budget was $1.5 billion. In 1991, $3 billion; from 9 percent of the budget to 14 percent of the budget. It is a big increase, yet our social safety net for many folks in Michigan is perhaps not as good as it was before. What can we do?

Mr. **Hollister**. Well, I——

Mr. **Upton**. Why haven't we been able——

Mr. **Hollister**. I would agree it is one of the fastest parts of the budget. It is because the way we organize the legislature and the way we organize Congress is fragmented, and it is hard to look at the whole system. I want to look at State employee health care costs.

The State is an employer. They have direct control over that as well. They are a purchaser of Medicaid. They use their dollar to purchase services. The health care for State employees has doubled that of Medicaid.

While Vernon is going to be here and talk about Medicaid and the struggle we have had, over that decade we have made 57 changes in policy with Medicaid. We did everything imaginable. We tried everything. We went to managed care. We did second surgical opinions. We stopped weekend admissions. It goes on and on and on.

We haven't initiated any cost containment for State employees, State retirees, school teachers, and those costs are going up between 6 and 800 percent in that same decade. We come at it singularly against the poor.

For the same—the State purchases medical care for State employees, State teachers and retirees, oh, not our problem. What do you mean it is not your problem? It is the State health care costs squeezing the budget. If you look at the aggregate, we went from 20 percent of the budget to 26.7 percent of the budget.

Why do we put all our guns on Medicaid? Why don't we have the same policies in Medicaid apply to State legislatures, health insurance? Well, hey, COPAY, you got to be kidding. We don't pay COPAY's. I am a State legislator, I don't pay COPAY's for nothing. I have got dental care and eye care and this and that.

Mr. UPTON. We have a lot of Members of Congress that would like to run for State Rep.

Mr. HOLLISTER. We welcome them. These new districts, they might be able to. We might all be looking for jobs. I think that is the point I was making. You can't just look at Medicaid, you got to look at the other pieces. You need a national program.

The last time I was there, we were talking about Oregon. They are struggling. We do it one way. Frankly, we are looking at the Oregon model as well. Medicaid is breaking us and there are politics to cut Medicaid. No politics to cut school teachers. The problem is the same. Health care costs cause pressures.

Mr. UPTON. Thank you.

Mr. DINGELL. The gentleman from Michigan, Mr. Conyers.

Mr. CONYERS. Thank you, Mr. Chairman. I want to demonstrate my ability to be brief, because lunch is here, and I know I would be thought very well of if I conduct myself accordingly.

First of all, my thanks to you for putting Representative Hollister on. Second, I have to find out if Hollister is available as a write-in candidate for the Democratic Presidency.

Mr. HOLLISTER. I am available for the draft.

Mr. CONYERS. Usually, draftees are very evasive about this subject, but I am glad you are so forthcoming. Finally, there is the question of fraud, which is one of the things that brings us here to this hearing about Medicaid. Part one, Part two.

What about the Blue Cross-Blue Shield third-party cheating that has gone on in this State for the last 15 years that I can track out of lawsuits—they keep losing the lawsuits, keep agreeing to pay up and never come around.

And second, what about all of these minority providers, the black doctors and pharmacists who are being prosecuted for Medicaid fraud because they filled out the wrong form or made an accounting error? For instance, one practitioner got prosecuted in one State for ninety-five cents difference in what the Medicaid hit team found he should have done.

Michigan's Medicaid fraud squad just hauled off a lady, a black female doctor and a member of Hartford Avenue Church, here in Detroit to a 12-year sentence just last month. I called her, Chairman Dingell, to ask her to come and listen to this hearing; they said she was taken to prison immediately after her trial. She is in the slammer, you can't get to her.

So I ask for your comments on that. That is my first question.

Mr. **Hollister**. Well, I don't know the specific case, but, again, it gets back to being not very smart on crime. Even if she were culpable, it doesn't make any sense to put her in prison. I would have her in a community center providing health care. My God, we can't get health care in the inner city of Detroit.

I think Vern can speak to the—Vern can speak to the problem. We are the payer of last resort. We keep getting shifted with the cost, too. It is one of the oldest problems out there. We aggressively pursue it. They have the resources to appeal, and that is where it goes and it drags on and on. They win by their tenacity.

Let me give you another problem, Congressman. Warren and I were here earlier this morning. We had a meeting at 8:00 at one of our mental health centers, and I just met with a primary care physician and it was very, very troubling.

As you know, many parts of the country are deinstitutionalizing the mentally ill. That is a program I have supported over the years, because I believe a comprehensive community mental health system can work if it is properly financed, but we haven't properly financed that system, and she was the primary caregiver for 42 group homes. The group homes in Michigan are six or less.

She just canceled her contract with all those 42 group homes, and those 42 group homes versus no primary care physician anymore because we are paying minimum wages, people are not trained. They are giving double medications, the wrong medications. They don't even have the blood pressure equipment in the facilities.

She said, "I can't take it any more." She said, "I am aware of several deaths. I am worried about my own liability." The system is falling apart and several hundred developmentally disabled people that she was giving primary care for are without health care today in this community. That is why we were running late. I couldn't believe the story she was telling.

People are falling through the cracks in massive levels, and I am deeply troubled. When I came before you in October, I said the system is collapsing. I am convinced today it has collapsed.

Mr. **Gregory**. I would like to add one thing that goes to your question. I think this is a function of the confusion, the high administering of compliance costs. We have a nursing shortage in this country, but yet, nurses graduate in greater and greater numbers each year.

Patient days go down, but yet our shortage grows greater, and that is because each year, nurses are forced to do more administration, more billing, more compliance, and that is the type of situation that this leads to. I think there is too much confusion in the system, and those who have the opportunity to manipulate the system have plenty of opportunity to do it.

Mr. CONYERS. Mr. Chairman, I said I would only ask one question and I kept my word. I close by—you know, this used to be your District many years ago. Most people have forgotten that.

Mr. DINGELL. It used to be our district.

Mr. CONYERS. Used to be mine, too. But at the risk of being thrown off your subcommittee, I have got four people that I have to acknowledge in the record. One is Susan McParland, one of the real great poverty lawyers, who is going to be a witness, and longtime friend of mine.

The other is Roberta Cottman at Wayne State University Pharmacy—is that Dr. Anderson sitting in—I had to mention his name.

The third is Barbara Wynder, the lawyer who has been working on these matters about discriminatory prosecution, which I know you will be interested in, as I am, with Norman Clements, the dentist, for so many years.

Finally, in the back is Stanley Stewart, who beats my brains out in tennis every time I am foolish enough to go out on the court with him. I thank you so much for yielding me so much time.

Mr. DINGELL. The Chair thanks the gentleman. Mr. Hollister and Mr. Gregory, we thank you for your assistance. Mr. Hollister, you have been before us several times. I regret to note we are now out of time, but I would like to State for the record, and leave the record open to have you and other witnesses to respond to some questions the subcommittee will be presenting to you.

I am particularly concerned with your views with regard to the panel which was initiated by Governor Milliken, continued by Governor Blanchard in the early 1980's. That panel had as its responsibility the question of how to provide food, shelter and primary health care to the needy on an emergency basis. If the staff were in touch with you, would you give us some assistance on what the recommendations were and what the outcome of the recommendations were?

Mr. HOLLISTER. I am glad you raised that, because in that recession, Governor Milliken became so alarmed, he declared a hunger emergency and actually opened a center in Lansing through the State police network that moved truckloads of food and they got farmers contributing food.

We had a whole number of operations moving food around; opening our National Guard shelters for homeless shelters and organizing physicians to provide primary care. That got worldwide attention. I am here to tell you today, circumstances got worse than they were when Milliken made that declaration.

Mr. DINGELL. Ladies and gentlemen, the Chair wants to thank all present, both our panel members and witnesses.

The Chair announces our next witnesses will be Dr. Vernon Smith, director, Medical Services Administration, Michigan Department of Social Sciences; followed by our County Executive, my good friend, Mr. Ed McNamara; and another panel composed of Susan McParland, staff attorney, Michigan Legal Services; Dr. David Adamany, president of Wayne State University, our host today; Mr. James Foster, administrator, Three Rivers Area Hospital.

The last panel will be Susan Adelman, past president of the Michigan State Medical Society; Mr. Richard Hiltz, representing the Michigan Hospital Association, also president and chief executive officer of Mercy Memorial Hospital.

The committee stands in recess. We will reconvene at 12:15.

[Whereupon, at 11:45 a.m., the subcommittee was recessed, to reconvene at 12:15 p.m., the same day.]

Mr. DINGELL. The subcommittee will come to order. Our next witness is Dr. Vernon Smith, director of Medical Services Administration, Michigan Department of Social Services. We are almost on time in recognizing you. We thank you for your presence today. We look forward to your testimony. You may consider yourself recognized for such statement as you wish to give.

STATEMENT OF VERNON K. SMITH, DIRECTOR, MEDICAL SERVICES ADMINISTRATION, MICHIGAN DEPARTMENT OF SOCIAL SERVICES

Mr. SMITH. Thank you, Mr. Dingell, Schaefer, Mr. Upton, other members of the committee. Governor Engler is unable to be here today. I am very pleased to be here, because the purpose of Medicaid is to assure access to mainstream health care for the most vulnerable of the citizens for this country is so important, and the amount of public funds is so great that we have to continually examine the program to see how we can accomplish the program's mission in the most effective way possible.

As we look at Medicaid, we find a series of paradoxes and apparent contradictions. We know, for example, that all the poor is not served by Medicaid. Nationally less than half of those below the Federal poverty line is served by Medicaid. In Michigan, perhaps 30 to 40 percent of those below the poverty line is not served. Yet at the same time we know that Medicaid serves over 1 million citizens of Michigan of the 11 to 12 percent of the population is in fact served by the program.

We know that doctors, dentists, other health care providers are increasingly departicipating or limiting their practice with respect to Medicaid. And yet, when we look at the data, we find that most doctors, most dentists and most health care providers and all the hospitals in this State do in fact participate and serve Medicaid patients.

We know that Medicaid patients sometimes cannot find a doctor for themselves or their child, yet when we look at the data, we find Medicaid patients see physicians at almost exactly the same rate as do other insured populations in this State, those covered by Blue Cross/Blue Shield Michigan, those covered by the State Employees Retiree Health Program, or other commercial health insurance. We know pregnant patients on Medicaid have an especially difficult time finding a physician to provide the prenatal care or deliver their baby. It seems a week hardly goes by but what we hear someone has difficulty finding a physician for a pregnant lady.

And yet, Medicaid covers the delivery, and most or all of the prenatal care for over 62,000 women in this State each year. That is over 41 percent of all the babies born in this State have their delivery paid for by Medicaid.

We know there are concerns about enrolling Medicaid patients in managed-care plans. Yet we find right now in Michigan, over a quarter of a million of the 950,000 eligibles have voluntarily chosen to enroll in a managed-care plan as their choice where they would like to receive care, whether that is through a patient loan plan or for a fee-for-service plan called a Physician Sponsored Plan in Michigan, which I know in Colorado there is a plan which has emulated that as well for Medicaid patients in Colorado. We know there are concerns about the quality of care in certain managed-care plans. When our studies have looked at the quality of care and access to care, we find managed care guarantees access to better care, that the quality of care is at least as good if not better, in fact our studies show that patients in managed care were 16 percent more likely to receive the care which they needed than those out in the regular fee-for-service system.

We know that Medicaid fees are low. We hear about that a lot. And yet even though Medicaid fees, what we pay for any individual service, is low, we look at the cost of the program and we find that costs have grown so fast and become so large that it is, I think, most would say, the most serious budget problem among the Nation's Governors, the State budget directors, and legislators, those who have to make the difficult decisions on the allocation of scarce public dollars.

Indeed, program cost, and I appreciated the eloquence with which Representative Hollister described this issue previous to my remarks, program cost is in fact the most significant issue, I think, in the program today. Medicaid operates in a health care marketplace where costs have increased at roughly twice the rate of increase for prices in general.

We have tried just about every cost containment measure that showed any promise at all of helping to control costs. Limiting eligibility, adjusting reimbursement rates, controls on coverage, limitations on coverage and the imposition of a variety of controls, all in an effort to try and control the cost of this very expensive program.

Still, costs continue to skyrocket at greater than other State programs and certainly greater than the growth in State revenues. In these very difficult economic times, when cutbacks are occurring across all State programs in virtually every State, it seems to me that the budget cannot survive a Medicaid program that goes like this, nor can the Medicaid program survive in economic times as these are, the budget situation we are in, the difficulty in State revenues not growing as fast as the program when we look at the causes of cost growth from the State perspective, one of the first places that we look at is what has come to be known as the unfunded Federal mandates. Much has been said on this issue. For brevity, let me reiterate that States cannot accept any further responsibility for program expansions without the funds to go with the new responsibilities.

In addition, State Medicaid programs can use some assistance to help control program costs, and help us move toward more effective programs. States need some room and some support for innovation and creativity. The current Federal labor process is obtuse and time consuming and discourages and obstructs State innovation. We need an opportunity for States such as Oregon and other States that have proposed innovations to have a chance to try those things which reflect the values, the interests, and the priorities of the policymakers in those particular States.

Second, I mentioned we need support for more effective managed-care programs. I mentioned our managed-care programs here and how we find they improve access, ensure and guarantee quality of care, and they serve to reduce costs. It turned out to be in the most recent study 10 percent less expensive, and fee-for-service followed in assuring quality of care and access.

The process right now for carrying out these kinds of programs requires waivers. It should be a State-planned option for Medicaid, and there are some other things which would simplify which are under consideration in other parts of the Congress now. We ask your support of those as well.

If the current Medicaid program is in fact to accomplish its purpose as a health care program of last resort and serve the health care needs of the poor in this country, we need assistance. It is important to have an effective and efficient program. The amount of money is too important and the health of the citizens of this country is so important that we need all the help we can get.

So we appreciate the fact this hearing is being held, that you are taking a look at it, and any assistance you can offer to make the program more effective, we certainly appreciate.

Thank you for the chance to present the testimony, Mr. Chairman.

[Testimony resumes on p. 116.]

[The prepared statement and attachments of Mr. Smith follow:]

STATEMENT OF VERNON K. SMITH, PH.D., DIRECTOR
MEDICAL SERVICES ADMINISTRATION
MICHIGAN DEPARTMENT OF SOCIAL SERVICES

MR. CHAIRMAN, I AM VERNON K. SMITH, DIRECTOR OF THE MICHIGAN MEDICAID PROGRAM. I AM PLEASED TO BE HERE TODAY AS A REPRESENTATIVE OF GOVERNOR JOHN ENGLER, AND GERALD MILLER, DIRECTOR OF THE MICHIGAN DEPARTMENT OF SOCIAL SERVICES. I AM HERE TO TESTIFY ON THE SEVERAL ISSUES AND PROBLEMS FACING MEDICAID PROGRAMS TODAY, AND THE OPPORTUNITIES FOR ADDRESSING THEM AT THE STATE AND FEDERAL LEVELS.

THE ORIGINAL PURPOSE OF MEDICAID, AS ARTICULATED IN 1965, WAS TO PROVIDE ACCESS TO MAINSTREAM HEALTH CARE FOR CERTAIN LOW INCOME AMERICANS, IN PARTICULAR FOR DEPENDENT CHILDREN AND THEIR PARENT OR PARENTS, THE DISABLED AND THOSE OVER AGE 65.

CONGRESS PROVIDED STATES THE OPPORTUNITY TO ADMINISTER MEDICAID AND TO STRUCTURE IT TO REFLECT THE PRIORITIES AND INTERESTS OF EACH OF THE STATES AND TERRITORIES. THE RESULT HAS EVOLVED INTO VERY DIFFERENT PROGRAMS IN EACH OF THE STATES AND TERRITORIES, EACH WITH ITS OWN SET OF COVERAGES, PAYMENT RATES AND ELIGIBILITY LEVELS. NO TWO OF THE 56 INDIVIDUAL MEDICAID PROGRAMS ARE THE SAME.

WHAT IS COMMON TO EACH MEDICAID PROGRAM, HOWEVER, IS THAT EACH SEEMS TO BE ACCOMPLISHING IN LARGE PART THE ORIGINAL PURPOSE OF

THE PROGRAM. ALLOW ME TO LIST SOME OF THE INDICATORS BY WHICH MEDICAID SUCCESS CAN BE MEASURED IN MICHIGAN:

* MOST MEDICAL PROVIDERS DO PARTICIPATE IN MEDICAID AND DO ACCEPT MEDICAID PAYMENT AS PAYMENT IN FULL. ACCESS TO HEALTH CARE DOES EXIST.
* MEDICAID SERVES OVER 1 MILLION MICHIGAN RESIDENTS EACH YEAR.
* MEDICAID PROVIDES PAYMENT FOR 5 MILLION PHYSICIAN VISITS PER YEAR. THE AVERAGE OF 5.1 PHYSICIAN VISITS PER ELIGIBLE PER YEAR IS IDENTICAL TO THE 5.1 AVERAGE EXPERIENCED BY OTHER INSURED POPULATIONS IN MICHIGAN AND IN THE UNITED STATES.
* MEDICAID PROVIDES PAYMENT FOR 180,000 INPATIENT HOSPITAL STAYS PER YEAR.
* MEDICAID PAID FOR DELIVERING OVER 40% OF ALL THE BABIES BORN IN MICHIGAN LAST YEAR. THIS AMOUNTED TO OVER 62,000 OF 153,000 BIRTHS.
* MEDICAID PAID PHARMACIES FOR ALMOST 12 MILLION PRESCRIPTIONS FOR MEDICAID PATIENTS LAST YEAR.
* MEDICAID PATIENTS WHO HAVE CHOSEN TO ENROLL IN HMOS FOR THEIR MAINSTREAM CARE NOW NUMBER OVER 150,000. AN ADDITIONAL 100,000 HAVE ENROLLED WITH A PHYSICIAN UNDER THE MICHIGAN MEDICAID PHYSICIAN SPONSOR PLAN.
* MEDICAID PAID FOR 12 MILLION PATIENT DAYS IN NURSING HOMES LAST YEAR. MEDICAID NOW PAYS FOR ALL OR PART OF THE CARE FOR 2/3 OF ALL NURSING HOME PATIENTS.
* OVER 30,000 MEDICAID RECIPIENTS WITH MENTAL HEALTH NEEDS

RECEIVED COMMUNITY-BASED REHABILITATION, CLINIC AND CASE MANAGEMENT SERVICES.

* OVER 27,000 PERSONS RECEIVED PERSONAL CARE SERVICES IN THEIR OWN HOMES, HELPING THEM TO CARRY OUT THE NORMAL ACTIVITIES OF LIFE AND AVOID PLACEMENT IN MORE RESTRICTIVE SETTINGS.

* MEDICAID PROVIDES CATASTROPHIC COVERAGE FOR SUCH SERVICES AS NEONATAL INTENSIVE CARE AND ORGAN TRANSPLANTS. MICHIGAN MEDICAID ANNUALLY IS PROVIDING COVERAGE FOR 5,000 NEONATAL INTENSIVE CARE CASES (AT A COST OF $90 MILLION) AND 150 ORGAN TRANSPLANTS (INCLUDING 67 BONE MARROW, 50 LIVER AND L4 HEART TRANSPLANTS, AT A COST OF $18 MILLION).

MEDICAID IN MICHIGAN IS NOW A $3 BILLION PROGRAM. THE MICHIGAN MEDICAID PROGRAM SERVES AS ITS OWN FISCAL INTERMEDIARY. LAST YEAR THE PROGRAM PROCESSED 50 MILLION CLAIMS. THE AVERAGE TIME ELAPSED FROM DATE OF RECEIPT OF A CLAIM UNTIL DATE OF PAYMENT FOR THE MICHIGAN MEDICAID PROGRAM IS LESS THAN 17 DAYS. FOR PHYSICIANS, PAYMENT IS MADE ON THE AVERAGE WITHIN 19 DAYS; FOR PHARMACIES, THE AVERAGE IS LESS THAN 15 DAYS.

THE MICHIGAN MEDICAID PROGRAM, LIKE OTHER STATE PROGRAMS, CARRIES OUT ITS DUTIES WITH COST EFFICIENCY WHICH IS THE ENVY OF THE HEALTH INSURANCE INDUSTRY. THE STANDARD MEASURE OF EFFICIENCY IN THIS AREA IS TOTAL ADMINISTRATIVE COSTS AS A PERCENTAGE OF CLAIMS PAID. FOR PURPOSES OF COMPARISON, I CAN TELL YOU THAT ON AVERAGE ADMINISTRATIVE COSTS AS A PERCENTAGE OF CLAIMS PAID ARE ABOUT 3% FOR MEDICARE, 6 TO 8% FOR A TYPICAL BLUE CROSS/BLUE SHIELD PLAN, 12 TO 15% FOR A TYPICAL HMO, AND UP TO APPROXIMATELY 30% FOR COMMERICAL INSURERS. FOR THE MICHIGAN MEDICAID PROGRAM, ADMINISTRATIVE COSTS AS A PERCENTAGE OF CLAIMS PAID (AT MEDICAID RATES) WERE 1.9% IN 1990 (THE MOST RECENT YEAR FOR WHICH COMPLETE DATA ARE AVAILABLE).

NOTWITHSTANDING THE SUCCESSES AND ACCOMPLISHMENTS IN MEDICAID IN MICHIGAN AND OTHER STATES, THERE ARE SEVERAL ISSUES AND PROBLEMS CURRENTLY FACED BY MEDICAID PROGRAMS WHICH MUST BE ADDRESSED.

1. INCREASES IN PROGRAM COST.

   FOREMOST AMONG ISSUES IS THE SEEMINGLY OUT-OF-CONTROL NATURE OF MEDICAID COSTS.

   MEDICAID COSTS ARE BREAKING THE BANK IN STATE TREASURIES ACROSS THE COUNTRY. MEDICAID COSTS IN MICHIGAN ARE NO EXCEPTION. MEDICAID PURCHASES HEALTH CARE IN THE SAME MARKETPLACE AS DO OTHER INSURERS, SELF-INSURED EMPLOYERS AND INDIVIDUALS. AS WE ALL KNOW, HEALTH CARE COSTS HAVE SKYROCKETED, INCREASING AT APPROXIMATELY TWICE THE RATE OF OTHER PRICES. HEALTH CARE EXPENDITURES HAVE DOUBLED IN THE LAST FIVE YEARS. BUT, BECAUSE OF THE NEED TO BALANCE STATE BUDGETS AND THROUGH CREATIVE COST CONTAINMENT MEASURES, MEDICAID PROGRAMS HAVE BEEN ABLE TO HOLD DOWN COSTS TO A LOWER RATE OF INCREASE; THE AVERAGE MEDICAID PROGRAM HAS DOUBLED IN COST OVER THE LAST 8 TO 10 YEARS. THE ATTACHED

TABLE DEMONSTRATES THAT, HAD MICHIGAN'S MEDICAID COSTS INCREASED AT THE RATE OF GENERAL MEDICAL INFLATION, MICHIGAN WOULD HAVE FACED $112 MILLION IN ADDITIONAL COSTS IN 1989.

NEVERTHELESS, THE MEDICAID PROGRAM HAS BECOME THE LARGEST SINGLE EXPENDITURE CATEGORY IN MORE THAN HALF THE STATES (ACCORDING TO THE NATIONAL GOVERNORS' ASSOCIATION). SOMETIMES WE'RE NOT SURE IF MEDICAID CAN SURVIVE THE BUDGET OR THE BUDGET CAN SURVIVE MEDICAID. IN MICHIGAN, EXPENDITURES HAVE INCREASED FROM $1.5 BILLION IN 1985 TO $3 BILLION IN 1991. AS A PERCENT OF THE STATE BUDGET, MICHIGAN'S EXPERIENCE HAS PARALLELED THAT OF MOST STATES, INCREASING FROM ABOUT 9% OF THE BUDGET IN 1985 TO 14% OF THE BUDGET LAST YEAR.

IN REVIEWING THE PROPOSED BUDGET FOR FISCAL YEAR 1992-93, WHICH WAS SUBMITTED BY THE GOVERNOR TO THE LEGISLATURE EARLIER THIS MONTH, I WAS STRUCK BY THE EXTENT TO WHICH MEDICAID NOW DOMINATES THE BUDGET FOR THE DEPARTMENT OF SOCIAL SERVICES. MEDICAID IS NOW OVER HALF -- 53% -- OF THE STATE'S LARGEST SINGLE BUDGET, UP FROM LESS THAN 40% JUST A FEW YEARS AGO. MEDICAID IS NOT ONLY THE PAC-MAN OF THE STATE'S BUDGET, IT IS THE PAC-MAN OF THE SOCIAL SERVICES' BUDGET AS WELL.

BECAUSE OF THESE BUDGET PROBLEMS, IT HAS BEEN NECESSARY TO CONSIDER DRASTIC REDUCTIONS IN THE PROGRAM ITSELF. LAST YEAR, THE LEGISLATURE CONSIDERED AND ADOPTED A RECOMMENDATION TO SUBSTANTIALLY SCALE BACK COVERAGES IN THE MICHIGAN PROGRAM. TARGETED FOR ELIMINATION WERE SERVICES SUCH AS HEARING, VISION, DENTAL, DURABLE MEDICAL EQUIPMENT SUCH AS WHEELCHAIRS, PROSTHETIC DEVICES, ORTHOTICS, SPEECH THERAPY, PHYSICAL THERAPY, OCCUPATIONAL THERAPY, PODIATRY AND CHIROPRACTIC SERVICES.

AFTER THE LEGISLATURE HAD ADOPTED THIS BUDGET, WE WERE ABLE TO DETERMINE THAT ALL OF THESE CUTS WOULD NOT BE NECESSARY IN ORDER TO LIVE WITHIN THE FUNDS WHICH HAD BEEN APPROPRIATED. AS A RESULT, ACTUAL PROGRAM CUTS WERE LIMITED TO THE FOLLOWING: ALL DENTAL SERVICES, INCLUDING DENTURES, FOR ADULTS; PODIATRY SERVICES; CHIROPRACTIC SERVICES; NON-ESSENTIAL NON-EMERGENCY TRANSPORTATION AND OUTREACH SERVICES FOR THE EPSDT PROGRAM. IN ADDITION, THE COPAY FOR PRESCRIBED DRUGS WAS INCREASED FROM 50 CENTS PER PRESCRIPTION TO $1.00.

WE ARE NOW AT OUR WIT'S END.

OVER THE PAST DECADE MEDICAID HAS IMPLEMENTED VIRTUALLY EVERY COST CONTAINMENT MEASURE THAT HELD PROMISE OF CONTROLLING COSTS.

Literally, there are very few options left that states can exercise on their own.

We need help.

I propose to the Committee that the time has come for Congress to examine how it has exacerbated the cost problem through unfunded mandates, and for Congress to commit to fully fund the federal responsibility, including the recent mandates.

The purpose of Medicaid is too important for states to attempt the job within the funding available to the states. As President Bush said in his State of the Union message last year, everyone in this country deserves good health care. We wish that we were in a better position to participate as full financial partners in this endeavor. Unfortunately, we cannot do so. Therefore, I strongly urge the Congress to fund the program fully and adequately so those purposes articulated by the Congress in 1965 can be fulfilled.

2. Unfunded federal mandates.

Since the mid 1980s, several mandates have been adopted by Congress which have contributed significantly to increases in Medicaid costs.

SINCE 1986, CONGRESS HAS MANDATED NEW MEDICAID EXPENDITURES FOR:

* ELIGIBILITY EXPANSIONS FOR PREGNANT WOMEN (TO 133% OF THE FEDERAL POVERTY LEVEL (FPL), AT STATE OPTION TO 185% OF FPL, AN INCREASE FROM MICHIGAN'S FORMER LEVEL OF ABOUT 58% OF THE FPL)

* ELIGIBILITY EXPANSION FOR CHILDREN UP TO AGE 6 (TO 133% OF THE FPL, AN INCREASE FROM 58% OF THE FPL)

* ELIGIBILITY EXPANSION FOR CHILDREN FROM AGE 7 TO 18 (TO 100% OF THE FPL, PHASED IN FROM OCTOBER 1, 1990 TO INCLUDE ALL CHILDREN BORN AFTER SEPTEMBER 30, 1983, SO ALL CHILDREN BELOW THE POVERTY LINE UP TO AGE 19 WILL BE ELIGIBLE FOR MEDICAID BY THE YEAR 2002).

* COVERAGE EXPANSIONS FOR CHILDREN'S SERVICES UNDER EPSDT, SUCH THAT ANY SERVICE REQUESTED BY AN EPSDT PROVIDER MUST BE PAID BY MEDICAID, EVEN IF IT IS NOT OTHERWISE A COVERED BENEFIT UNDER THAT STATE'S MEDICAID PLAN.

* SERVICE EXPANSIONS FOR NURSING HOME SERVICES REQUIRING MEDICAID REIMBURSEMENT FOR INCREASED NURSING HOME STAFF AND OTHER SERVICES ABOVE THAT WHICH WAS THE COMMUNITY NORM FOR MANY FACILITIES.

- Reimbursement mandates for retrospective full-cost payments for selected groups of providers, such as Community Health Centers, Migrant Health Centers and Health Centers for the Homeless.

Many of these mandates have had the objective of assuring health care for otherwise uninsured low income children and pregnant women. We cannot argue with this objective.

However, this improved health coverage comes at a considerable cost which states cannot now afford.

I offer as one specific example the cost of expanded eligibility for pregnant women and children up to 133% of the poverty line (at state option up to 185% of the federal poverty level).

Michigan adopted the option of 185% of the federal poverty level in 1988. At that time, it was forecast that annual expenditures would total approximately $12 million per year. In light of budgetary expectations in 1988, the present situation is quite striking. Specifically, the expanded coverage for pregnant women, infants and children up to age 8 is projected to cost $100.3 million in FY 1992.

STATES ARE STAGGERING UNDER THE WEIGHT OF THESE INCREASED COSTS. IF CONGRESS IS TO FORCE STATES TO ADOPT PARTICULAR POLICIES, CONGRESS MUST BE WILLING TO FULLY FUND THE MANDATES AS WELL. WE AT THE STATE LEVEL CANNOT ACCEPT CAPS ON FEDERAL MEDICAID CONTRIBUTIONS. WE ARE WILLING TO WORK TOGETHER TO CONTROL THE COSTS OF HEALTH CARE, BUT WE SHOULD DO SO IN A WAY THAT TRULY CONTAINS COSTS, AND DOES NOT JUST SHIFT COSTS FROM THE FEDERAL GOVERNMENT TO THE STATES.

3. MANAGED CARE.

OUR FISCAL YEAR 1993 BUDGET IS ALSO PREDICATED ON A SIGNIFICANT MANAGED CARE EXPANSION. MICHIGAN HAS BEEN A LEADER IN MANAGED CARE FOR MANY YEARS. OUR FIRST HMO CONTRACT WAS SIGNED IN 1972. MICHIGAN INAUGURATED ONE OF THE NATION'S FIRST PRIMARY CARE CASE MANAGEMENT PROGRAMS IN 1982. THIS APPROACH, WHICH IN MICHIGAN IS CALLED THE PHYSICIAN SPONSOR PLAN (OR PSP), IS DESIGNED TO ENSURE THAT MEDICAID PATIENTS CAN SELECT A PRIMARY CARE PHYSICIAN WHO HAS AGREED TO PROVIDE OR AUTHORIZE ALL MEDICAL CARE REQUIRED FOR THAT PATIENT. WE NOW HAVE CONTRACTS WITH OVER 1,200 DOCTORS WHO SERVE AS PHYSICIAN SPONSOR/CASE MANAGERS. OVER 100,000 MEDICAID PATIENTS ARE NOW ENROLLED WITH A PHYSICIAN THROUGH PSP.

OUR EVALUATIONS DOCUMENT THE BENEFITS OF MANAGED CARE WITH RESPECT TO COST SAVINGS, ACCESS AND QUALITY OF CARE. SPECIFICALLY, OUR EVALUATIONS SHOW THAT PATIENTS ENROLLED IN MANAGED CARE INCUR HEALTH CARE COSTS APPROXIMATELY 10% LESS THAN THAT OF PATIENTS IN REGULAR FEE-FOR-SERVICE SITUATIONS. ACCESS IS ASSURED, 24 HOURS PER DAY, 7 DAYS PER WEEK, PER THE TERMS OF THE CONTRACT WHICH MANAGED CARE PROVIDERS SIGN. COMPLIANCE WITH THE ACCESS PROVISIONS OF THE CONTRACT IS ENFORCED THROUGH REGULAR SURVEYS AND FOLLOW-UP TO ENSURE THAT GENUINE ACCESS DOES EXIST.

OUR EVALUATION OF QUALITY WAS CONDUCTED BY THE MICHIGAN PEER REVIEW ORGANIZATION. MPRO LOOKED AT THE MEDICAL RECORDS OF PATIENTS IN MANAGED CARE AND THOSE WHO WERE NOT, AND CONCLUDED THAT MEDICAID PATIENTS IN A MANAGED CARE SITUATION ARE MORE LIKELY TO RECEIVE THE CARE WHICH IS APPROPRIATE TO THE PATIENT'S CONDITION, AND THEY ARE 16% MORE LIKELY TO RECEIVE ALL OF THE CARE WHICH IS APPROPRIATE FOR THEIR MEDICAL SITUATION.

WE HAVE FOUND THE BENEFITS OF MANAGED CARE TO BE SO COMPELLING THAT WE HAVE CHARTED A COURSE TO ENROLL ALL 950,000 MICHIGAN MEDICAID PATIENTS IN MANAGED CARE OVER THE NEXT 2 YEARS. THIS MEANS WE HAVE TAKEN ON THE AMBITIOUS CHALLENGE OF ENROLLING 700,000 MEDICAID PATIENTS WHO NOW RECEIVE CARE IN THE FEE-FOR-SERVICE SYSTEM. THROUGHOUT 1992, WE ARE MARKETING MEDICAID TO THE 11 MICHIGAN HMOS WITH

WHOM WE DO NOT YET HAVE A CONTRACT, AND WE ARE WORKING WITH THE MEDICAL COMMUNITY TO LAY THE GROUNDWORK FOR SIGNING CONTRACTS UNDER THE PHYSICIAN SPONSOR PLAN WITH PHYSICIANS ACROSS THE STATE. OUR GOAL IS TO ENROLL AN ADDITIONAL 100,000 MEDICAID PATIENTS IN MANAGED CARE SITUATIONS BY NEXT OCTOBER 1. TO DO SO WILL INVOLVE ENROLLING ALL THE REMAINING 100,000 MEDICAID ELIGIBLES IN WAYNE COUNTY WHO ARE NOT YET IN MANAGED CARE. BEGINNING NEXT FALL, WE WILL BEGIN THE ENROLLMENT OF THE REMAINING 600,000 MEDICAID PATIENTS IN THE URBAN AND RURAL AREAS OF LOWER MICHIGAN AND EVENTUALLY THE UPPER PENINSULA AS WELL.

WE ARE ALSO UNDERTAKING A PROJECT TO APPLY MANAGED CARE CONCEPTS TO MENTAL HEALTH CARE. IN COLLABORATION WITH DMH AND THE NETWORK OF PUBLIC COMMUNITY MENTAL HEALTH PROVIDERS, WE ARE EXPLORING WAYS TO ENSURE ACCESS, CONTINUITY OF CARE AND COST EFFECTIVE SERVICE SELECTION FOR THE MEDICAID POPULATION.

AS WE ATTEMPT TO PROCEED WITH THIS EXPANSION IN MANAGED CARE, WE FIND THAT CERTAIN FEDERAL REQUIREMENTS ARE STANDING IN OUR WAY. RATHER THAN PROMOTING MANAGED CARE, THE FEDERAL GOVERNMENT IS ACTING AS AN UNCOOPERATIVE PARTNER. I CALL YOUR ATTENTION TO S. 2077 INTRODUCED BY SENATOR MOYNIHAN. THAT LEGISLATION WOULD AMEND SECTIONS 1902 AND 1903 IN SUCH A WAY AS TO ALLOW MEDICAID PROGRAMS TO OPERATE CASE MANAGEMENT SYSTEMS MORE EFFECTIVELY. SPECIFICALLY, THIS

PROPOSED LEGISLATION WOULD REQUIRE INTERNAL QUALITY ASSURANCE SYSTEMS IN LIEU OF THE ARTIFICIAL 75/25 ENROLLMENT MIX REQUIREMENT, IT WOULD SIMPLIFY THE FREEDOM OF CHOICE WAIVER REQUIREMENT, AND IT WOULD SIMPLIFY THE HCFA APPROVAL REQUIREMENT ON HMO CONTRACT RENEWALS. WE NEED THE FLEXIBLILITY ALLOWED BY S. 2077 TO IMPLEMENT OUR MANAGED CARE PROGRAMS.

4. DRUG REBATE PROGRAM.

CONGRESS SHOULD BE COMMENDED FOR THEIR EFFORTS TO REDUCE MEDICAID PHARMACEUTICAL COSTS. WE WHOLEHEARTEDLY AGREE THAT MEDICAID SHOULD RECEIVE DISCOUNTS AVAILABLE TO HOSPITALS AND HMOS. HOWEVER, THE OBRA 90 DRUG REBATE PROGRAM HAS POTENTIAL TO COMPLICATE RATHER THAN SIMPLIFY A STATE'S ABILITY TO DETERMINE COST-EFFECTIVE DRUG COVERAGES AND TO NEGOTIATE PHARMACEUTICAL REBATES.

ALONG WITH IMPLEMENTING MANUFACTURER REBATES, CONGRESS IMPOSED MANY NEW REQUIREMENTS ON STATES:

- MOST NEW PRODUCTS MUST BE COVERED FOR 6 MONTHS WITHOUT PRIOR AUTHORIZATION

- PHARMACY PRIOR AUTHORIZATION REVIEWS MUST BE COMPLETED WITHIN 24 HOURS AND THE STATE'S RESPONSE MUST BE BY TELECOMMUNICATION

- FOR 4 YEARS, STATES CANNOT CHANGE THEIR PAYMENT METHOD IF PHARMACY PAYMENTS WILL BE LOWERED

- STATES MUST IMPLEMENT DRUG USE REVIEW PROGRAMS INCLUDING PHARMACIST-PATIENT COUNSELING AND MEDICAID EDUCATION PROGRAMS WITH PHARMACIES AND PRESCRIBERS ON DRUG INTERACTIONS

REBATE PAYMENTS WILL BE SIGNIFICANT. HOWEVER, INTENSIVE PROGRAM AUDITS WILL BE REQUIRED TO RESOLVE MANUFACTURER DISPUTES ON UTILIZATION DATA. MORE IMPORTANTLY, CONGRESS HAS TAKEN AWAY OUR ABILITY TO MANAGE THE DRUG PROGRAM AND DETERMINE COVERAGES BASED ON INPUT FROM OUR OWN STATE'S MEDICAL AND PHARMACY COMMUNITIES. STATES ARE BEST SUITED TO FASHION THEIR OWN DRUG PROGRAMS, TO ESTABLISH FORMULARIES AND TO CONDUCT UTILIZATION REVIEW. WE REGRET THIS UNFORTUNATE LOSS OF STATE FLEXIBILITY.

5. BOREN AMENDMENT.

THE BOREN AMENDMENT SPECIFIES THAT MEDICAID REIMBURSEMENT FOR HOSPITALS AND NURSING HOMES MUST BE SUFFICIENT TO MEET THE FULL COSTS OF AN ECONOMICALLY AND EFFICIENTLY OPERATED INSTITUTION. THE ORIGINAL INTENT OF THE BOREN AMENDMENT WAS TO ENSURE THAT MEDICAID DID NOT PAY TOO MUCH. THAT AMENDMENT HAS NOW BEEN INTERPRETED BY THE COURTS TO MEAN

THAT MEDICAID MUST ESSENTIALLY PAY FULL COSTS INCURRED BY THESE INSTITUTIONS.

MICHIGAN IS AMONG THE 2-DOZEN STATES WHICH HAVE FACED LAWSUITS BROUGHT BY HOSPITAL AND NURSING HOME ASSOCIATIONS. IN OUR CASE, A COURT-ORDERED SETTLEMENT INCREASED OUR INPATIENT COSTS BY $70 MILLION LAST YEAR, AND OUR NURSING HOME COSTS BY APPROXIMATELY $15 MILLION LAST YEAR.

WHILE WE HAVE NO QUARREL WITH THE GOAL OF FAIR PAYMENT FOR QUALITY NURSING HOME SERVICES, WE BELIEVE THAT THE IMPACT OF THE BOREN AMENDMENT HAS THE EFFECT OF FUNNELING MANY MORE RESOURCES INTO INSTITUTIONAL REIMBURSEMENT, OFTEN AT THE EXPENSE OF COMMUNITY-BASED ALTERNATIVES, WHICH DO NOT HAVE "MANDATE" STATUS. MICHIGAN, ONE OF THE PIONEERS IN THE USE OF PERSONAL CARE FOR COMMUNITY-BASED SERVICES, IS NOW BEING FORCED TO CONSIDER LIMITS ON THIS SERVICE.

IT IS OUR RECOMMENDATION THAT CONGRESS SPECIFY IN LAW A CLEARER DEFINITION OF WHAT IS MEANT BY "ECONOMIC AND EFFICIENT." THIS WOULD ALLOW MEDICAID PROGRAMS TO ESTABLISH REIMBURSEMENT METHODOLOGIES WHICH WOULD IN FACT ENCOURAGE EFFICIENT AND ECONOMIC COSTS, AND COULD HAVE THE RESULT OF SAVING TENS OF MILLIONS OF DOLLARS CURRENTLY EXPENDED FOR HOSPITAL AND NURSING HOME SERVICES.

6. FEDERAL REQUIREMENTS FOR DOCUMENTING PROVIDER PARTICIPATION.

PURSUANT TO SECTION 6402 OF OBRA 89, STATE MEDICAID PROGRAMS ARE REQUIRED TO DOCUMENT THE PARTICIPATION OF PHYSICIANS WHO PROVIDE OB AND PEDIATRIC SERVICES. THE INTENT EVIDENTLY IS TO DOCUMENT THAT SUFFICIENT PROVIDER PARTICIPATION EXISTS TO ASSURE ACCESS TO OB AND PEDIATRIC CARE. I CAN TELL YOU THAT THE TRUE EFFECT OF THIS SECTION IS TO FOSTER CREATIVITY TO GENERATE DATA WHICH WILL NOT LEAD TO IMPROVED ACCESS TO CARE.

CONGRESS WOULD BE BETTER SERVED TO SEEK DATA ON THE QUALITY OF CARE, THE ACCESSIBILITY OF CARE, AND THE SATISFACTION WITH CARE PROVIDED TO MEDICAID PATIENTS, VIS-A-VIS MAINSTREAM AMERICANS.

7. FEDERALLY-QUALIFIED HEALTH CENTERS.

FEDERALLY-QUALIFIED HEALTH CENTERS ARE PART OF THE BACKBONE OF HEALTH CARE DELIVERY FOR LOW-INCOME AMERICANS. THESE COMMUNITY HEALTH CENTERS, RURAL HEALTH CENTERS AND HEALTH CENTERS FOR THE HOMELESS DO AN EXEMPLARY JOB OF SERVING MEDICAID AND NON MEDICAID PATIENTS ALIKE.

OBRA 89 INCLUDED REQUIREMENTS THAT MEDICAID REIMBURSE THESE HEALTH CENTERS FOR THEIR FULL COSTS. MEDICAID PROGRAMS, HOWEVER, HAVE BEEN MOVING AWAY FROM FULL-COST REIMBURSEMENT.

FULL-COST, COST-BASED REIMBURSEMENT HAS THE WRONG INCENTIVES WITH RESPECT TO EFFICIENCY AND ECONOMY. IT IS A REGRESSIVE STEP TO REQUIRE THAT MEDICAID OFFER SUCH FULL-COST RETROSPECTIVE PAYMENT IN THE CASE OF FEDERALLY-QUALIFIED HEALTH CENTERS, NOTWITHSTANDING THE FINE JOB WHICH THEY DO SERVING THIS PATIENT POPULATION.

IF THE INTENT OF CONGRESS WAS TO ASSURE THE ECONOMIC VIABILITY OF THESE HEALTH CENTERS, IT WOULD BE FAR BETTER TO DO SO DIRECTLY WITH FEDERAL FUNDS THROUGH THE PUBLIC HEALTH SERVICE THAN TO DO SO BY MANDATING SUCH PREFERENTIAL REIMBURSEMENT THROUGH MEDICAID. WE ARE CONCERNED THAT THIS PREFERENTIAL TREATMENT OF ONE PROVIDER TYPE WILL SURELY LEAD TO ADDITIONAL LITIGATION ON THE PART OF OTHER INSTITUTIONS AND PROVIDERS WHO FEEL THEY SHOULD ALSO BE REIMBURSED THEIR FULL COSTS FOR SERVING THE MEDICAID POPULATION.

8. AUDIT AND DISALLOWANCE REFORM.

WE ARE CONCERNED THAT HCFA AUDITING PRACTICES MAY RESULT IN MULTIMILLION DOLLAR DISALLOWANCES OF FEDERAL FUNDS FOR MINOR PROCEDURAL INFRACTIONS.

STATES ARE SEEKING CONGRESSIONAL ASSISTANCE IN FOCUSING THE AUDIT AND DISALLOWANCE PROCESS ON AREAS AFFECTING QUALITY OF CARE AND EFFICIENT PROGRAM OPERATION, RATHER THAN MINOR PROCEDURAL REQUIREMENTS.

The federal government has the right and responsibility to audit state Medicaid programs. States contend that the audits should focus on items that adversely affect quality of care or efficient program administration. If an audit reveals a procedural error that does not affect quality, eligibility, or appropriateness of services provided, the state should be allowed an opportunity to come into compliance without financial penalty.

Senator Chafee has introduced S. 1240 which addresses these concerns. Under the bill, states would be allowed to come into compliance without financial penalty in situations where HCFA finds that the infraction does not adversely affect quality of care or result in provision of medically unnecessary or inappropriate services. S. 1240 also would prohibit a disallowance when a state operates in accordance with an approved state plan.

We believe that this legislation would have a positive impact on oversight of the Medicaid program because it would focus audits on those areas where quality of care is in jeopardy rather than where large disallowances are possible.

9. Waivers.

States need more latitude to shape their own programs. In order to implement or continue to operate an innovative (and

SOMETIMES A "MAINSTREAM") PROGRAM, STATE STAFF MUST SPEND MONTHS OF EFFORT APPLYING FOR WAIVERS AND DOCUMENTING THE COST-EFFECTIVENESS OF PROGRAMS FOR WAIVER RENEWAL. HCFA'S WAIVER PROCESS IS IN DIRE NEED OF IMPROVEMENT. INSTEAD OF SETTING UP ROADBLOCKS, HCFA SHOULD BE ENCOURAGING UNIQUE APPROACHES LIKE THE OREGON PRIORITY-SETTING PROJECT. BUT, THE CUMBERSOME AND TIME-CONSUMING WAIVER PROCESS HAS KEPT OREGON MEDICAID STAFF BUSY FOR MONTHS, IF NOT YEARS. MY STAFF SHOULD BE PURSUING INITIATIVES TO IMPROVE QUALITY OF CARE, EXPAND SERVICES AND ASSESS ALTERNATIVE DELIVERY METHODS RATHER THAN COMPLYING WITH HCFA WAIVER POLICIES THAT DO LITTLE TO FOSTER CREATIVITY AND INNOVATION. IN HIS NATIONAL ADDRESS ON HEALTH CARE REFORM IN CLEVELAND EARLIER THIS MONTH, PRESIDENT BUSH COMMITTED HIS ADMINISTRATION TO FLEXIBILITY, AND A STREAMLINED WAIVER APPROVAL PROCESS. WE ENCOURAGE EFFORTS BY CONGRESS TO STREAMLINE THE WAIVER PROCESS IN ANY WAY POSSIBLE.

10. FRAUD AND ABUSE.

FRAUD AND ABUSE WILL ALWAYS EXIST IN MEDICAID. BUT, WE HAVE A NUMBER OF OVERSIGHT MECHANISMS TO CATCH AND CORRECT ABUSES. THE FIRST IS MICHIGAN'S MEDICAID FRAUD CONTROL UNIT (MFCU), WHICH IS HOUSED IN THE DEPARTMENT OF THE ATTORNEY GENERAL. THE COOPERATIVE RELATIONSHIP BETWEEN THE MFCU AND OUR MEDICAID PROGRAM IS EXEMPLARY.

THE SECOND MAJOR OVERSIGHT MECHANISM IS THE SURVEILLANCE AND UTILIZATION SUBSYSTEM OF OUR MEDICAID MANAGEMENT INFORMATION SYSTEM. THIS SYSTEM ALLOWS ANALYSIS OF PATTERNS OF PROVIDER AND RECIPIENT ACTIVITY, WITH RESULTANT RECOVERY OF MEDICAID FUNDS AND THE CORRECTION OF THE ACTIONS RESULTING IN OVERPAYMENTS. IN ADDITION, DOCTORS MAY BE EXCLUDED FROM MEDICAID PARTICIPATION AND RECIPIENTS PLACED IN UTILIZATION CONTROL PROGRAMS THAT ASSURE ACCESS ONLY TO ABSOLUTELY NECESSARY SERVICES.

FINALLY, OUR MEDICAID PROGRAM PROVIDES ESSENTIAL INFORMATION TO OTHER AGENCIES, SUCH AS THE STATE'S HEALTH PROFESSIONS LICENSING AUTHORITIES, THE DEA, THE OFFICE OF THE U.S. ATTORNEY AND THE FBI. COOPERATION WITH THESE AGENCIES HAS RESULTED IN A NUMBER OF CRIMINAL CONVICTIONS, CIVIL RECOVERIES, MONETARY PENALTIES AND LOSS OF PHYSICIAN LICENSURE.

THESE MECHANISMS ARE GENERALLY EFFECTIVE IN CONTROLLING FRAUD AND ABUSE. HOWEVER, EVEN SUCCESSFUL EFFORTS AGAINST WASTE ARE ADVERSELY AFFECTED BY FEDERAL POLICY AND STATUTE. MICHIGAN HAS LOST MILLIONS OF DOLLARS TO THE BANKRUPTCY STATUTES AND PROVIDER BANKRUPTCY DECLARATIONS AFTER THE STATE HAS OBTAINED RECOVERY JUDGEMENTS. ALSO, FEDERAL POLICY REQUIRING A STATE TO SEND TO THE FEDERAL GOVERNMENT IDENTIFIED OVERPAYMENTS FROM FRAUD AND ABUSE BEFORE THE STATE COLLECTS THEM CREATES PROBLEMS. GIVEN THE OFTEN

LENGTHY PROCESS REQUIRED TO ESTABLISH AN AMOUNT OWED BY A PROVIDER TO MEDICAID, STATES ARE PUT IN THE POSITION OF HAVING TO PAY THE FEDERAL GOVERNMENT LONG BEFORE THEY CAN RECOVER THE FUNDS AT ISSUE. WE WOULD WELCOME AN IMPROVED FEDERAL-STATE PARTNERSHIP TO HELP US IN RECOVERY/CORRECTIVE SITUATIONS.

11. MEDICAL SUPPORT AND ERISA.

MICHIGAN'S STATUTE AND FEDERAL REGULATIONS REQUIRE THAT CHILD SUPPORT ORDERS INCLUDE THE OBLIGATION THAT PARENTS PROVIDE HEALTH CARE COVERAGE TO THEIR CHILDREN WHEN AVAILABLE THROUGH THEIR EMPLOYERS. MANY STATES ARE ATTEMPTING TO ENSURE THAT PARENTS PROVIDE THIS HEALTH CARE COVERAGE; HOWEVER, THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA), WHICH PROHIBITS STATES FROM REGULATING SELF-FUNDED EMPLOYERS, PREVENTS STATES FROM ENACTING SUCH LEGISLATION. BECAUSE MOST OF THE LARGE EMPLOYERS IN MICHIGAN ARE SELF-FUNDED, THE MEDICAID PROGRAM LOSES A SIGNIFICANT OPPORTUNITY TO COLLECT THIRD PARTY LIABILITY PAYMENTS FROM ABSENT PARENTS. WE WOULD WELCOME A CHANGE IN ERISA TO MAKE IT POSSIBLE FOR US TO REQUIRE ABSENT PARENTS TO PROVIDE INSURANCE.

CONCLUSION.

IN CONCLUSION, WE HAVE MUCH TO BE PROUD OF IN THE MICHIGAN MEDICAID PROGRAM. IN THE FACE OF CONTINUED FISCAL CONSTRAINTS, WE HAVE PROVIDED PAYMENT FOR COMPREHENSIVE, MAINSTREAM HEALTH CARE FOR MILLIONS OF LOW-INCOME RESIDENTS. BUT, WE FACE NUMEROUS CHALLENGES. IN PARTICULAR, WE SEEK YOUR HELP IN STRENGTHENING AND REFINING OUR FEDERAL-STATE PARTNERSHIP. STATE MEDICAID PROGRAMS HAVE BEEN THE LEADERS IN PROVIDING COST-EFFECTIVE HEALTH CARE. BUT, STATES NEED THE FREEDOM TO IMPLEMENT NEW APPROACHES AND TO OPERATE WITHOUT UNDUE INTERFERENCE IF STATES ARE TO CONTINUE TO PROVIDE FUNDING FOR THIS PROGRAM. THE FEDERAL-STATE PARTNERSHIP MUST BE FLEXIBLE ENOUGH TO ALLOW INNOVATION AND CREATIVITY TO FLOURISH. HOWEVER, MEDICAID PROGRAMS CANNOT CARRY THE BANNER OF COST CONTAINMENT ALONE. THIS COUNTRY NEEDS TO MAKE A CONCERTED EFFORT TO GET HEALTH CARE COSTS UNDER CONTROL. STATES CANNOT BE EXPECTED TO SHOULDER THE ADDITIONAL BURDENS OF THE POOR AND UNINSURED OR ADDITIONAL SERVICE COVERAGE WITHOUT INCREASED FEDERAL FUNDING AND SUPPORT. STATE ATTEMPTS TO GENERATE ADDITIONAL FUNDING FOR WORTHWHILE PROGRAMS HAVE BEEN THWARTED LEGISLATIVELY, AND WE NEED FEDERAL ASSISTANCE TO ASSURE THAT WE HAVE THE RESOURCES TO MEET THE NEEDS OF OUR MEDICAID BENEFICIARIES.

THANK YOU FOR THE OPPORTUNITY TO PRESENT MY VIEWS. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS.

MICHIGAN MEDICAID
TRENDS IN RECIPIENTS AND EXPENDITURES
FISCAL YEAR 1992 - FISCAL YEAR 1991

FISCAL YEAR	RECIPIENTS	EXPENDITURES
1982	1,174,833	$1,292,630,601
1983	1,187,612	1,421,703,450
1984	1,155,165	1,574,044,207
1985	1,133,317	1,516,607,539
1986	1,119,724	1,767,799,061
1987	1,125,047	1,823,426,565
1988	1,104,770	1,806,466,966
1989	1,018,934	1,939,094,843
1990	1,047,963	2,194,769,814
1991	1,112,533	2,540,086,697

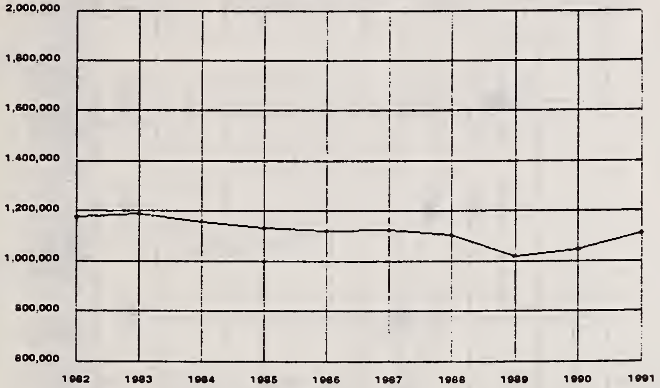
Recipients = Unduplicated count of eligibles who received at least one service

Expenditures do not include capitation payments

Source: HCFA-2082

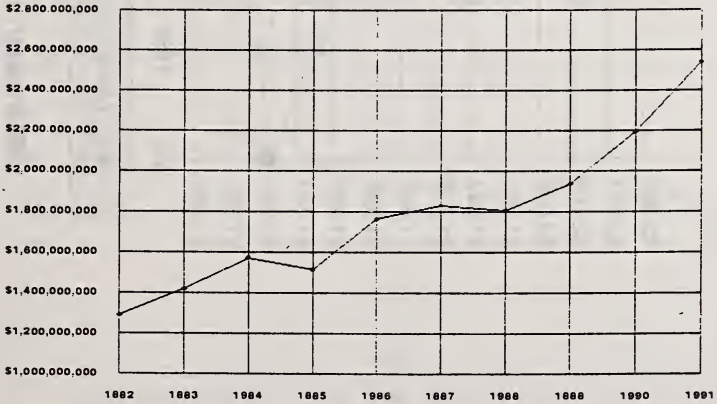
Medicaid Recipient Population

Source: HCFA-2082



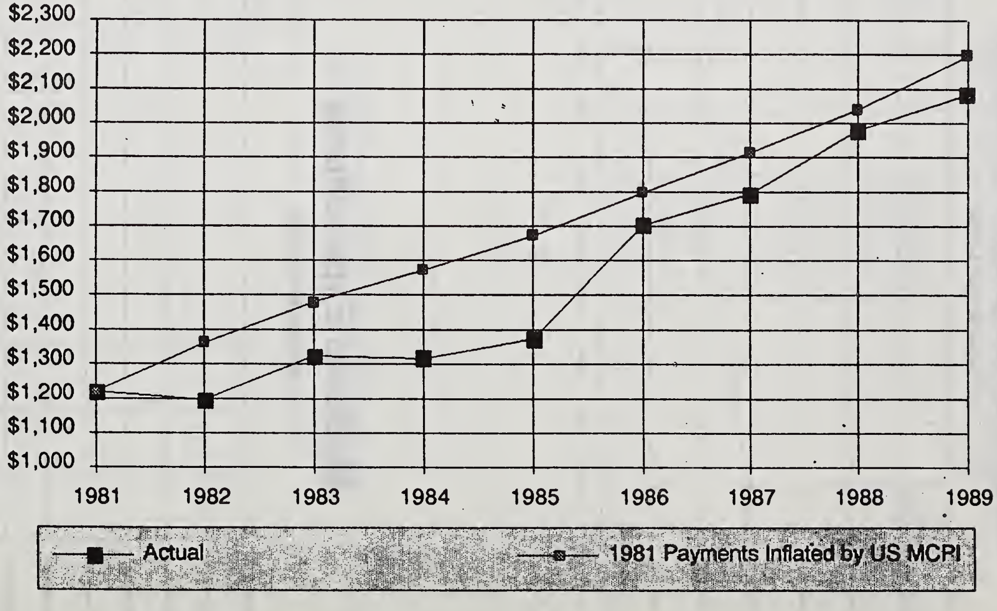
Medicaid Expenditures

Source: HCFA-2082



Medicaid vs. Health Care Inflation

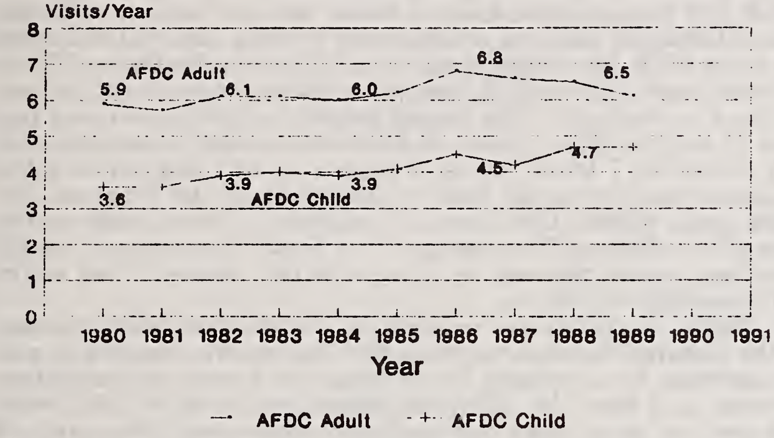
(In Millions)



1985 through 1989 Medicaid Expenditures include Capitation Payments

Physician Visits Per Person

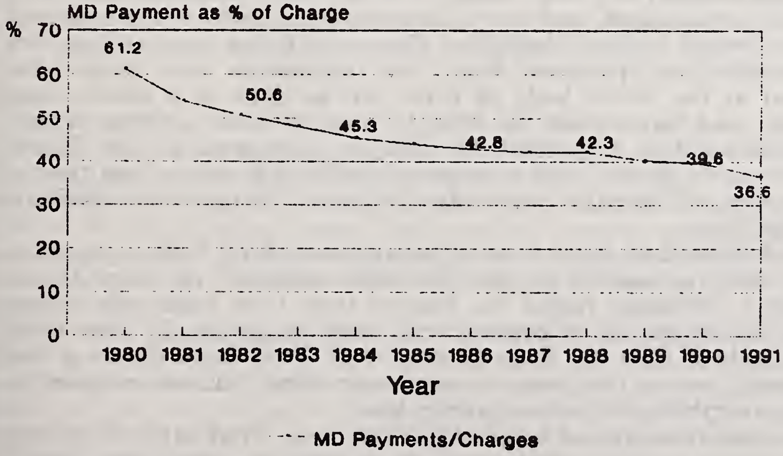
Michigan Medicaid 1980 - 1989



Non-Institutionalized AFDC Only

Ratio of Physician Payments to Charges

Michigan Medicaid 1980 - 1991



Michigan Claims Processing Data for MDs

Mr. Dingell. We very much appreciate your presence and your very helpful testimony. I am sure my colleagues will have a number of questions they will want to direct to you. I recognize my good friend from Colorado, Mr. Schaefer.

Mr. Schaefer. Thank you, Mr. Chairman. Dr. Smith, I appreciate the fact you are here today. I know you are familiar with our State of Colorado, and you are welcome to keep coming out as you have since 1982. We always need those dollars in the State. Colorado, for example, this year, if I am not mistaken, was about $40 million short on Medicare. This caused the State legislature many moments of anguish. We operate on a balanced budget amendment as many States do. I know you have tried a lot of things to curb the cost increases here in the State of Michigan, in the program, but despite your efforts, there are a number of factors, such as the policy of the Federal Government, that limits the degree to which States can control the cost in growth. Is that correct? You might want to specify on that.

Mr. Smith. Certainly our constraints are the Medicaid programs and the Federal/State partnership. The States are required to provide coverage for a certain list of what are known as mandatory coverages, and have the ability to choose from a list of 33 of what are known as optional or nonmandatory coverages, things such as prescribed drugs or physical therapy, just to name a couple of the so-called options. Plus there is a large body of Federal regulations which control and constrain what a State can do.

We are continually looking for more effective ways to provide care, and that requires us to seek waivers, and the waiver process, as I indicated, is very obtuse. We are looking for ways—it would help us a lot if there were ways to streamline that particular process so we can do things which are more innovative.

It would also help us if some of the constraints in terms of what we had to cover and how it is covered could be reconsidered. I look just as an example, and not to necessarily endorse every aspect of what Oregon is doing, but what Oregon is doing is appealing to a State Medicaid program from the perspective that they have looked at the whole body of what can be done in a health care system, and have taken the time to work with the citizens of that State to create a prioritized list. This isn't one person's list. This is a list which derived out of a lot of study and review and the involvement of literally thousands of interest groups and individuals in that State.

And what they have done is to say, everything that a physician does isn't necessarily as effective and necessary as other things which a physician might do. And so they have been able to say some things should be covered and some things can be done more effectively if they are done another way. They have drawn a line and said, we are not going to cover everything, but we are going to cover everybody below the poverty line.

So they have raised their eligibility level. That kind of innovation, again, I think what needs to be done is that States should have the ability to design the system which best reflects the priorities and interests of the policymakers in that State. But that is a very fascinating experiment, and right now it is not allowed without some special consideration.

Mr. **Schaefer**. One of the concerns I have always had is regarding the health care for our senior citizens. I know a number of doctors I have talked to in Colorado have shown me the costs of an examination of one kind and what their reimbursement is. My fear is we are going to have more and more physicians drop off, and we are going to reduce the assistance to the people who are going to provide the service to these individuals. As a matter of fact, it is against the law, but a lot of their senior patients know that this rate difference is there, and they want to pay their doctor cash to make it up so that they will keep seeing them. Of course, that is illegal, and no one I know is doing this.

This is a major concern of mine. Is this a concern here in the State of Michigan?

Mr. **Smith**. What is our concern is that payment rates have not kept up with the rate of inflation. I have a chart which shows how Medicaid charges as a result of what doctors charge has changed over the last 10 years. Ten years ago our payments were about 60 percent of what physicians charged. Last year it dropped down to 36 percent. We just recently had a fee increase which would take it back up to around 40 percent. But still you can see there has been a very significant drop in what Medicaid pays, not just in absolute numbers, but relative to what the market is.

Mr. **Schaefer**. Do you have this fear that I do?

Mr. **Smith**. I think it is a very legitimate—it is not just a fear, it is a fact. Physicians in various parts of the State have chosen to limit Medicaid practice, and in some cases departicipating completely from the Medicaid program because what Medicaid pays in their view is not sufficient to cover their actual costs.

Mr. **Schaefer**. This Federal mandate situation, would you agree or not that the Federal mandates imposed by us in Washington are the most significant factors in these increasing costs?

Mr. **Smith**. There is no doubt about it. The mandates have in fact increased costs. Again, I think the important thing to keep in mind is that States are able to carry out the program, and some of the mandates have been positive in their ultimate impact, but States simply do not have the fiscal capacity to absorb the cost. That is what the issue is.

Mr. **Schaefer**. I was in my own doctor's office not too long ago, getting a physical exam and all that, and of course when we walk into one, the first thing they say is, wait a minute, I want to talk to you about something. They showed me the form which has to be adhered to and filled out every time a patient comes in under this particular program. It is astronomical, and if there is one mistake made, they are in violation of the law. Has this been a common concern here, too?

Mr. **Smith**. There is a lot of concern nationally about what I will call a common claim form. There are about 1,400 different insurance companies and health plans, many of which have different health forms. We do need to have some commonality here. In this State we have worked very carefully with Blue Cross, Medicare and Medicaid, which together have the vast majority of the business, and we have reached commonality of the forms. But it is an important issue in terms of minimizing the administrative costs of the providers.

Mr. Schaefer. As these mandates have increased, Federal funds have decreased, is that correct, in most cases?

Mr. Smith. Federal funds have not kept pace with the demands, that is correct.

Mr. Schaefer. So this leads you into sort of a problem here, as well as in other States?

Mr. Smith. That is correct.

Mr. Schaefer. Let's get to the drug rebate issue. You said that the Federal Government's so-called drug rebate program was designed to save money, but has actually cost the Medicaid program more money. You cited a large number of administrative problems with it. Are you saying you believe this will cost you more because of the administrative burden, or you can call it the hassle factor?

Mr. Smith. The hassle factor is a mess. We have got new authority to obtain new staff through the legislature in order to administer this. I think it is very important, and Congress was on the right track trying to control drug costs, which have been one of the fastest rising components of Medicaid and other health programs across the country.

In the effort to try to get Medicaid a best price, there have been—there were conditions placed on that, which limit a State's ability to control the costs in a most effective way, to look at what are the most effective pharmaceutical products that could be covered, to look at appropriate utilization controls or prior authorization techniques that may be appropriate to specific products. All of those options have in essence been taken away by this new constraint associated with the drug rebate.

Don't get me wrong, the drug rebate will be significant, in this State possibly $30 million a year return to the State, 95 percent of which will be shared back with the Federal Government. But it is—the strings attached to it do create quite an administrative hassle.

Mr. Schaefer. So the strings attached to it is not allowing it to work to the degree we would like it to work?

Mr. Smith. That is correct.

Mr. Schaefer. Mr. Chairman, I will pass it on now.

Mr. Dingell. Appropriate. The Chair recognizes now my good friend from Michigan, Mr. Upton.

Mr. Upton. Thank you. Dr. Smith, one of my focuses as well as the subcommittee's focus is ferreting out fraud, waste and abuse. Last year we had some sterling testimony from the FBI, the Inspector General of HHS, as well as other witnesses around the country, and I think it was even in the chairman's opening statement about as high as 15 percent of Medicare/Medicaid expenditures are fraudulent.

And as we have found out from our hearing last year, with regard to what the witnesses told us, the bulk of the Medicaid fraud has not been perpetrated by the participants of the program, but rather by physicians, even hospitals, large networks of pharmacies, drug diverters, ambulance service companies, a whole host of different associations who you might otherwise suspect on the surface.

One of the things I am interested in, I know the subcommittee is as well, is what has Michigan done, what has the State of Michigan done to identify, A, the cost, and B, what steps are being taken in terms of cases? How do you go about determining the level of abuse in the system, and what are some of the things you and the administration are doing?

Mr. Smith. Well, Congressman Upton, you are asking a question about a very important part of Medicaid activity. Fraud and abuse are two very difficult areas to get after and come to a specific number to quantify.

I have seen estimates up to 15 percent. It doesn't matter what it is, if there is anything at all going on, it is too much. We have a number of efforts to try to identify it and put the information in the proper hands so that prosecution or recovery or whatever the appropriate action may be actually does take place.

There is a very organized, systematic process for analyzing claims which come in—every claim that comes in is subject to approximately 400 edits through our system before it does get paid. In the course of going through that process, the computer does a lot of analysis and identifies situations which may appear to merit further review.

We have staff which take a look at that and, through that process, a number of situations may result in further investigative review and action. At the same time, a lot of the information comes to us by way of phone calls. Someone sees or becomes aware of a situation, and they will call. We have toll-free hot lines for this purpose and that information is passed along.

There is a special Medicaid fraud unit within the Michigan Deputy Attorney General. We do have cooperative arrangements with the DEA, the FBI, other major players such as Blue Cross, so it is possible to take a look at it.

All I can say to you is it is a very important activity. It is absolutely essential we identify and prosecute and control. There is so much money involved in this program that sometimes people get a little greedy. When that happens, we have to be able to identify it quickly.

Mr. Upton. Are you satisfied with the degree of success the State has had?

Mr. Smith. I think there is always room for additional success in this area. We never seem to have as many resources as we would like to have in order to identify what is out there. The cost-benefit ratio—benefit-cost ratio is very high. The return is very high, given the amount of resources we do invest.

Mr. Upton. One other area I would like to focus on in terms of my questions: I travel around my part of the District; which as you know is southwestern, south central part of the State. As I meet with the medical societies, county associations, my hospital administrators, one of whom is here today; my nurses, patients, the level of frustration is very high. Our family just had a new child and Blue Cross-Blue Shield forms are something else to try to understand, to figure out where you send them.

The level of frustration and the lack of standardization, whether they be for an elderly person having difficulties to see the forms, or perhaps even understand them, is the highest that I can imagine. I would be interested in what steps you would encourage us to take back with us. What are some of the steps you are trying to undertake within the State, both to standardize those forms, to expedite the payment to the individuals, because it is a nightmare.

I am a cosponsor of H.R. 2625. I don't know most bill numbers off the top of my head, but I have received hundreds of letters from physicians in my District. I imagine many of us on this committee are also cosponsors on this bill to reduce paperwork burdens on physicians.

As you look at a number of different proposals, pay or play. Many of them in terms of a cost saving to have a standardized type of form. What dramatic steps have you taken, and what would you encourage us to do to try and achieve that same goal?

Mr. SMITH. Again, we are talking about the possibility of simplifying the administration. The cost of health care right in the doctor's office, where the billing form is actually filled out, it has to be very frustrating in a group practice of any size, you will have a billing person that specializes in Medicare, another one specializes in Medicaid, another specializes in Blue Cross, and another in Aetna and Prudential.

It doesn't make sense. It would serve everyone's interest, providers and third-party payers, if we had a form that could be used by everyone. A lot of resources have been put into this issue in the past, and we have been frustrated because the needs of one third-party payer for information or to have a particular form is such that it might preclude the adoption of a form that might be useful for other persons.

In the case of Medicaid, for example, the efficiency of our system is dependent on having a form that is optically scanable so it can be mechanically read and put into the system. A lot of the forms that have been proposed so far have not been optically scanable.

I think technology is coming up to a point where we should be able to take a look at it. We certainly support the principle.

Mr. UPTON. Thank you. I yield back.

Mr. DINGELL. The Chair thanks the gentleman. The gentleman from Michigan, Mr. Conyers.

Mr. CONYERS. Thank you very much, Chairman Dingell. I want to welcome Dr. Smith, and indicate this is our very first and formal way of meeting, and that you have figured into my work, my appraisals and my dreams for much more than you know, sir. Now we are together, and I am very happy for that, because in your tender mercies lie the future of the North Detroit General Hospital and Southwest Detroit Hospital.

I believe you have met the trustee of Southwest Hospital, Dr. William Anderson, a good friend of both of ours, in trying to fashion a way to pull Southwest out of Chapter 11. One of the ways that John Gorman on my staff has recommended, is that if we move toward this Federal qualified health center concept in an effort to keep these facilities open, and if we can maintain their hospital status and add this community health center concept, your office would, of course, be very important in that effort. We are grateful to have you here and to be working along with you on this matter.

Problem: Even if we reimburse the Medicare and Medicaid patients at 100 percent of reasonable cost, as mandated by law for these health centers, I have been told that you have some reservations about that as a practice, and I would like you to address that at this point.

Mr. SMITH. Sure. Thank you, Congressman Conyers. I do want to say, first of all, we are very pleased to have a chance to resolve the issues with North Detroit and South Detroit. We are happy to work toward the resolution.

The issue which you raised with respect to federally qualified health centers and the reimbursement which, let me say, the special reimbursement provisions which were specified in OBRA 89 for those community health centers, migrant health centers, rural health centers that qualify at the so-called FQHC's, what Congress did in that provision was to specify that these centers are entitled to full cost reimbursement, unlike other Medicaid health care providers.

My concern is simply one, as a matter of health care policy in general, we have been moving away from full cost retrospective reimbursement for all the other providers under Medicaid, because the incentives of that kind of a system are not those which might encourage economy and efficiency.

We would like to have a reimbursement system because it is one of the most powerful ways we can bring about a cost-effective health care system. We like to have a system which encourages the efficient delivery of health care.

Our only concern has to do with that special classification of them as being entitled to full cost retrospective reimbursement. We have no qualms whatsoever of the mission and accomplishments of federally qualified health centers. They are doing a great job serving the poor and low-income populations of this State. I believe there are 22 such centers currently qualified, and anything we can do, again, to support them we are happy to do. That is the only concern. That is the law, and we are happy to comply with the law as it is right now, and we are doing so.

Mr. CONYERS. As one of the supporters of that provision, may I respectfully point out to you that that incentive was built in because we need these centers so desperately. There is an absolutely urgent need in rural and urban areas to do that, and that is why we made this the only exception in Federal health regulation and policy.

Now that we have breached that, here is the next problem in this possible reconfiguration at these facilities. If you come into, let's say, this prospective new health center arrangement at these facilities, and you don't have Medicare and you don't have Medicaid, which 60 percent of the eligible don't have, then guess what? We are building a grave site over this community health center, because many, if not most of the people, will come in uninsured, uncovered by these two modest provisions.

And it is there I have begun to sleep less comfortably in my bed at night. I mean, we take a hospital that is in Chapter 11, such as North Detroit General or Southwest. We resurrect it as a community health center under the Federally Qualified health center statute, and then we find out there is a big financial gap here because the people pouring in don't have anything to pay—100 percent of zero is still zero.

And so, you know, I am wondering if in our legislative brilliance, we are leading two hospitals in desperate circumstances down another path in which they are going to get in trouble. I need you to worry with us about it, because it is unfair to be just leading them from one dead end to another.

Mr. SMITH. Congressman, we will be glad to work with you and the hospitals and the U.S. Public Health Service, which has some authority over qualifying these as well.

Mr. CONYERS. Now, with reference to fraud. You know, it is funny now, and I have to speak frankly to you about this. I work a lot on anti-drug efforts with the so-called anti-drug czar in Washington, and I have been chairman of the Criminal Justice Subcommittee in Judiciary, as well as the Crime Subcommittee at different times.

Twelve percent of the drug users, according to our national government, are minorities, but 40 percent are the ones being prosecuted. I am beginning to wonder if this disparity doesn't translate into the question of Medicaid fraud. We have to keep the questions of race very much in front as we move in on these malefactors.

We have got a young female African-American doctor that, as of less than a few weeks ago, was sentenced to 12 years in prison. I thought she would be at this hearing to hear our concerns about her case and this problem, but Dr. Robertson is no longer a citizen with rights. I wanted to bring your attention to the growing number of complaints that I am receiving, naturally, about the Medicaid providers, many of whom are minorities, out of the necessity of the reality, who will be prosecuted on very minuscule complaints, trivial amounts of money, misfilings under lots of paperwork, and I need to make sure we are sensitized and work on this.

I understand we are bringing in 50 more FBI Agents to prosecute Medicaid fraud. Well, if they are going to be squirreling around looking into the inner city at doctors that are so weighted down with Medicaid cases that they can hardly continue to practice, we are going to miss the boat where the really serious cases and much greater amounts of fraud are occurring—and I am not trying to rationalize small amounts of fraud.

Any violations of our laws are violations of our laws. But when the emphasis appears to be misdirected upon minority practitioners and pharmacists, we have a problem. Has this been brought to your attention before this point?

Mr. SMITH. Congressman Conyers, actually, it was just 1 or 2 weeks ago this issue was brought to my attention. It caught me by surprise at the time. I had always been aware, or it was my understanding our identification processes for looking at who we would investigate were totally colorblind.

I simply asked my people, could there possibly be any basis to this suggestion there would in any way be any consideration of minority status or any other kind of status, and I was assured—they were surprised as I that such a suggestion might have been made.

I can't—as I understand the system, I can't imagine how this kind of bias might creep into it, but I am certainly happy to take a further look at it, if that would be helpful. The—our resources are so limited, as I suggested before, in looking at the whole area of fraud and abuse that there is no way we are going to focus our efforts where it appears that it might be unproductive. So I am a little surprised by the suggestion that this may be going on.

Mr. Conyers. Well, I know people are always taken by surprise by the ugly face of racism in America, particularly inside our own government. Unfortunately, I have spent more than two decades working on that. But I have a report on this that I will begin to acquaint you with. It was prepared by Dr. Norman Clements, a professional person who himself has been the object of what were claimed to be unfair investigations into Medicaid health care providers.

Finally, are you aware of the GAO study that I initiated on the Medicaid third-party reimbursement problem with Michigan Blue Cross-Blue Shield?

Mr. Smith. I am.

Mr. Conyers. You are aware of this problem. Could you give us a capsule report on how the question of the millions of dollars of reimbursement due to the Medicaid program are involved there, and how it is coming along under your command. I realize you have only been in this capacity for a relatively short period of time.

Mr. Smith. I will be glad to bring you up to date. The issue here is finding a way to make sure Medicaid only pays what it is responsible for. Where there is a third-party payer, such as Blue Cross, who has primary responsibility, Medicaid is the last payer, last resort.

The issue here, I believe, if I can summarize it briefly, Blue Cross-Blue Shield of Michigan is the major payer in this State, so as it turns out, a significant number of not large—a significant number of Medicaid patients have dual coverage under Blue Cross and Medicaid.

The Blue Cross coverage may come about because the father, before a divorce, is employed by General Motors, for example, and as part of the court child support order, the health care coverage is continued while the child is a minor.

We have worked with Blue Cross to—in every way possible, and as you suggested before lunch, including lawsuits, to try to make sure that the Blue Cross liability is fully paid.

We have had in the last 2 months formal correspondence between Mr. Whitmer, the President of Blue Cross-Blue Shield, and Dr. Miller on this subject. We have recently been able to acquire the reports which we had been expecting last since last fall. We are in the process of looking at those reports, and to make sure the full and complete Blue Cross liability is, in fact, paid. We will be working with the Auditor General in this State to make sure what we have is exactly what we need, and it has been processed correctly.

Mr. Conyers. I thank you very much. There was always the computer problem, which I found an incredible alibi. It was explained to me that the Medical Services Administration didn't have the capability to put together a computer that could track the costs, which even as a computer-illiterate Member of Congress, I found disturbingly unrealistic.

I had people piously come into my office more times than I care to tell you about saying that as soon as you get the computer, this is going to be simple. And I am almost afraid to ask you if you ever got the computer, but I am going to ask you anyway.

Mr. SMITH. We have a problem of one computer talking to another, one talking the same language as another. We have different kinds of computers between Department of Social Services and Blue Cross. Therein lies a serious issue. We have worked out these problems.

Mr. CONYERS. The chairman is raising his gavel. I don't know if it is to strike me or tell me the time is up. I yield back the balance of my time. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman.

Doctor, as you stated, Michigan is not alone in fighting Medicaid's biggest single drain on its budget. You specified you reduced. You also testified there has been significant reductions in the funding levels to a number of Medicaid programs, and a number of these funds include some key preventive programs for both children and adults; for example, 60,000 low-income children no longer have access to health screenings, including immunization, hearing and vision tests, and psychological assessments. Is that correct?

Mr. SMITH. Mr. Chairman, that which you are referring to would be the EDSPC outreach, the early periodic screening diagnosis and treatment program is an important component of Medicaid programs across the country. It specifically serves children, and it is designed to do exactly those things which you just described.

Outreach is a mandatory portion of that program, meaning making children and their parents aware of the program, making sure they—arranging transportation as it may be necessary. There are many ways to carry out outreach.

One of them has been a contract with the Department of Public Health which has been in the amount of $5 or $6 million through which they would arrange scheduling and transportation and so on for the children to come in.

There has been a fear which has not yet materialized to the extent you just described, that because the outreach funds were not there, that people would not be able to come in. I have seen an estimate of the size you just mentioned of 60,000 not being able to come in as a result. The benefit is still there. That has not changed.

What has changed is the ability—the capacity to reach out and find these children who are eligible and to assist them in making sure they do keep an appointment and they get the follow-up services which they need.

Mr. DINGELL. Now, Doctor, prior to these cuts, Michigan had been one of the country's leaders in covering optional Medicaid services, was that not so?

Mr. SMITH. Michigan covered a few more than the national average. There are 33 optional services, Michigan covered 27 of them. I think the most any State covered was maybe 30 or 31, but at the current time, we are pretty close to the median of all States, which is 24.

Mr. DINGELL. Now, optional services included such things as oxygen, durable medical equipment, vision and dental services, nonambulance medical transportation, physical occupational speech therapy, hospice care, and in some instances, substance abuse programs, podiatry and chiropractic; is that not so?

Mr. SMITH. That is correct.

Mr. Dingell. Are those eliminated?

Mr. Smith. No, they are not eliminated, all of them, but the list which you just described is a list which was part of the budget discussions in the Michigan Legislature.

Representative Hollister would have been in a better position to describe the discussions that took place in the legislature. The elimination of those services was part of the executive budget which was proposed last September and adopted by the legislature last September for our fiscal year, which began on October 1st.

It turns out that after that budget was adopted, we took a look at that because we wanted to be sure we covered as many of the services that could be within the funds that were in fact appropriated, and we made a decision to include all of the services as continued coverages, with the exception of dental services, podiatry, chiropractic, EDSPC outreach, and some substance abuse services that had been provided in acute setting.

With those exceptions, the services did continue, including such things as durable medical equipment, oxygen, wheelchairs, and so forth.

Mr. Dingell. Now, you referred to HCFA's waiver process. I would like to hear your thoughts on that. We may have to write you a letter in view of our time constraints to ask you additional questions about that. But that has been a significant problem for us here in Michigan, has it not?

Mr. Smith. The waiver process, Mr. Chairman, has been very difficult for us in Michigan. We have prided ourselves as being a program that tried to be innovative and forward-looking to take advantage of the latest policy directions so we could have as tight a program as possible. To do that, you need to have waivers.

Notwithstanding HCFA's assurances over the last several years that the waiver process would be streamlined, the fact of the matter is that we have literally spent hundreds, probably thousands of hours trying to get waivers in order to carry out these programs, the home-community-based waivers, waivers that allow us to do managed care, waivers that would allow us to serve Medicaid-eligible patients in their home instead of in institutions, things along that line. And the process is simply very, very obtuse.

One of the things I would suggest for the committee to look at is whether some of these programs which currently require waivers and have been documented as effective and useful programs in State after State shouldn't just be optional coverages under the program so the State could opt into it if they so chose, as long as they met certain criteria.

Mr. Dingell. Could you give me a more amplified statement on that particular point about converting many of these from waiver programs to optional programs?

Mr. Smith. I would be pleased to submit that.

Mr. Dingell. The gentleman from Colorado?

Mr. Schaefer. No questions.

Mr. Dingell. In the case of Oregon, Oregon wanted to go to a new program which would deal with health care delivery to everyone in the State. They sought to proceed under the waiver process. Are you aware of how they succeeded or failed on that particular matter?

Mr. SMITH. Mr. Chairman, it is my understanding that that waiver is still under consideration with HCFA, and a decision has not been made yet to my knowledge. But it has been a long process for Oregon as well.

Mr. DINGELL. What do you think of the Oregon plan?

Mr. SMITH. I give a lot of credit to the people of Oregon for taking the time to focus on a way to more effectively deliver health care, to try to find a way to look at that health care which is most effective so that scarce tax dollars can be focused on those things which are most needed and, at the same time, structure it so that everyone up to the Federal poverty level would be covered.

I think that is a very commendable initiative. The fact that it has involved such a broad spectrum of every interest that could be identified within Oregon to be part of that process says to me that the process itself has been very worthwhile and they have developed a proposed plan which meets the priorities, interests and valuation of that State. And I would commend them for their effort, and I wish them well. I hope very much it works.

Mr. DINGELL. How is the waiver process working with regard to this matter?

Mr. SMITH. It is my understanding that the waiver process has gone very, very slowly in my discussions with people——

Mr. DINGELL. Is it so slow as to create a problem?

Mr. SMITH. So slow as to delay their proposed implementation date, yes.

Mr. DINGELL. Dr. Smith, the committee is grateful to you for your very helpful testimony. We will probably have some questions by letter. If you would like, we would appreciate being able to do that.

Mr. SMITH. That would be just fine. Thank you for the opportunity to speak with you today.

Mr. DINGELL. Thank you very much for your assistance. We appreciate it very much. Thank you.

The Chair announces the presence of a valued friend and distinguished public official, Mr. Edward McNamara, County Executive of the County of Wayne. Thank you for being with us today.

Mr. MCNAMARA. Thank you.

Mr. DINGELL. Mr. Conyers and I know of your many accomplishments here in the County.

STATEMENT OF EDWARD H. McNAMARA, EXECUTIVE, WAYNE COUNTY, MICHIGAN, ACCOMPANIED BY DEBORAH SCOTT

Mr. MCNAMARA. Good to be here. I appreciate getting on as quickly as this. I am not sure whether I am busy or disorganized.

Chairman Dingell and honorable members of the committee, I appreciate your invitation to testify before the committee on the state of our health care system in Wayne County.

As you examine the strengths and shortcomings of our health care delivery system across America, no doubt you are learning many of the lessons we have learned here in the Detroit area over the past decade. The benefits of the world's finest medical care are becoming available only to an ever-shrinking group of our citizens. Despite skyrocketing health care costs, many of our health care providers must still struggle to balance their bottom lines, and our poorest citizens must struggle the most to achieve even basic levels of health care.

In Wayne County, which is home to the City of Detroit and 42 other communities, we are well acquainted with all of these problems. Six years ago, health care costs nearly drove Wayne County out of business. It is my hope that by sharing with you some of our solutions to our health care dilemma, we may offer some ideas for future remedies.

When I took office in January of 1987, Wayne County had a deficit of $135 million, caused almost entirely by an inefficient system of providing mandated health care to the county's indigent population.

Under the old system, indigent persons in Wayne County were ineligible for most types of medical care, except emergency room treatment and hospitalization. Their treatment costs were fed into the bureaucracy of our State government, which processed the bills. Sometimes it took months, sometimes years, before compensating providers and then passing the bills back to Wayne County for payment.

Our system mandated that the County have no control over treatment and no role in controlling costs. All we were allowed to do was open our wallets and close our eyes. That system tripled our health care costs in only 5 years.

Our solution, called County Care, is the result of taking back control of our health care costs. Together with the State legislature, we were able to build what amounts to a county-run HMO for 43,000 poor people. Cost-controlling incentives for patients, for government and providers have been built into every step of the process. This new emphasis on cost control has encouraged responsible treatment.

Profits now come from preventive medicine, since we pay hospitals $77 per month per person, whether that person has a checkup or a triple bypass. And as we all know, it is cheaper to treat someone with medication for high blood pressure than it is to pay the cost of emergency room treatment and a hospitalization for a stroke victim.

The results: Preventive care is up, costs are down, our deficit has been eliminated, and Wayne County has balanced its budget for the past 4 years. And our coverage has not led anyone to stint on care. In fact, preventive office visits have increased instead of emergency room visits.

As a public official with an eye on the bottom line, County Care makes me very happy. The program has received its share of awards and received impressive bipartisan support from our State legislature and Governor John Engler last year, at a time of severe budget cuts across the State of Michigan.

We are working on ways to expand the program to cover the County's working poor. We believe the program can be made attractive to small businesses who, for minimal costs, will be able to offer their employees an attractive benefit, paid health insurance.

As I said, we have learned from all of this. Our most important lesson is that governments usually make lousy doctors. We only have two cures for the problem of health care delivery. We either expand our bureaucracy until the system dies of bloat and poor circulation, or we panic and amputate every program in sight. In both cases we forget there are live people at the other end of our decisions, people who are sick and will only get sicker unless we help.

At Wayne County, our experience has taught us if you don't manage your health care costs, they will manage you. Our old system practiced management by default. Sickness forced hospital visits. Legal obligations forced medical treatment. And blind bureaucracy forced blind payments.

We decided not to put up with that bloat, and I honestly cannot understand how government can amputate health programs. If we cannot care for the least among us, how can we call ourselves civilized?

I encourage this committee to give more thought to traveling the same road we did, a middle road. Managed health care with a strong emphasis toward preventive care and with incentives for good performance by patients, providers and government has given us good health care and a healthy bottom line.

I have enclosed a summary of our programs and welcome your questions.

Mr. DINGELL. Thank you very much. You have given us very helpful testimony.

I would note your program is an extraordinarily fine program, well run. What is the cost of that program per person?

Mr. McNAMARA. It is $77 per month per person. We negotiate for a 3-year period. We have four health care providers, so there is competition. If one provider says I can't do it for $77, we have three others who say they can. It has worked very well for us. We started out at $73 a month, and we have had a couple of increases over the last 4 years and brought it to $77.

But again, we know what it is going to cost us, and these health care providers know that if they can keep poor people healthy, they are going to make more money and let those poor people become ill and still only receive the $77.

Mr. SCHAEFER. Thank you, Mr. Chairman.

Mr. McNamara, prior to you coming in, I read your statement, and am truly impressed with what you have been able to accomplish. You are to be commended.

I might follow a question the chairman asked; $77 per person. What about a family? What about a family of four? Is there a reduced rate there?

Mr. McNAMARA. If they qualify as indigents, we pay based upon—now, these people are all over 21 years of age, and they go up to age 65.

Mr. SCHAEFER. I am just a bit confused, though. Are you still in the Medicaid program?

Mr. McNAMARA. In the Medicaid program? Oh, yes. In fact——

Mr. SCHAEFER. The reason I ask is, you were given, apparently, a lot of leeway to get this all put together in such a new style.

Mr. DINGELL. Will the gentleman yield?

The gentleman is giving the good news. Mr. McNamara is giving the bad news. Bad news is this program is functioning pending the request for a waiver. Fact is, this program is functioning with no Federal funds at all.

Mr. McNamara. At this point, it is State and county funds, but the State, because of its financial condition, is trying to move this into a matching arrangement with Federal funds. Just as Pennsylvania, for instance, has done.

Mr. Dingell. And you have a request pending for waiver at HHS?

Mr. McNamara. That is correct.

Mr. Dingell. If that waiver is not granted, what then happens?

Mr. McNamara. We are back to the State, because we have 43,000 individuals who have to have health care one way or the other. We start a body count then, if the program dissolves itself.

Mr. Schaefer. As I say, we are talking about all the hoops and hurdles that everybody has to jump through, following the Medicaid thing, and it seems to me you just completely revamped a program. I was trying to figure out how you got through all these hoops and hurdles. So it has been clarified to me now that you are in for a waiver to HHS.

Mr. McNamara. We are now. I have to point out that the County is not diminishing its role. It is not diminishing its contribution. It is the State that is having a great difficulty with its budget, so the State is using our dollars to match Medicaid dollars in order to fund this program at the level the State has been funding it in previous years.

Mr. Schaefer. If you continue with what you are doing, they could not pick this up in Lansing or in Ann Arbor, or anyplace else in the State, as far as counties—I am not familiar with all your counties, but——

Mr. McNamara. Over half the indigents in the State of Michigan reside in the County of Wayne. So when you take the other 83 or 82 counties, obviously the indigent population is very small, and hospitals have less of a problem just absorbing that.

Mr. Schaefer. So they may not have the need. But can I go to the city of Denver—and this is where our major population of indigents is—and hopefully copy something of what you did?

Mr. McNamara. We would love to have you do it.

The other thing that is fascinating about this program, and I point to people in my staff who have been developing this, is if we want to do this for so-called underemployed, the working poor, we believe that we can take this same program. And we realize that the first step is to go to the providers and get them to agree to reduce their costs.

But we believe that with a one-third contribution from the employer, a one-third contribution from the Federal Government or the State government or local government and a one-third contribution maybe from some source of taxation, that we could provide this same kind of service for a large group of people out there today that have no health care.

We believe, for instance, that for just a few dollars a month the people working for Little Caesers could have health care, and this would be an incentive to stay rather than if they develop an illness or become pregnant to actually quit their jobs to become an indigent so they can receive health care through this program.

Mr. Schaefer. Is this the first time this has been done?

Mr. McNamara. To my knowledge, yes.

Mr. SCHAEFER. Of course, we haven't thought about the Chicago, Illinois area or any other large area, Washington, D.C. area, et cetera.

Mr. MCNAMARA. We did it because of crisis.

Mr. SCHAEFER. It is amazing what we can do when we are pushed to the wall.

Mr. MCNAMARA. We had $135 million deficit. We had absolutely no way of resolving that deficit. We were running $50,000 a day over budget just for health care costs when we took this program to the State. The bureaucrats in the State level, probably, had there not been a crisis, would not have supported us. They had the alternative of accepting this program or taking over the county of Wayne and running it, and they weren't doing that great a job with the State of Michigan, so it was very doubtful they would improve on how the State ran.

It was a crisis and ending up with the county of Wayne giving us the right to create county care. They gave us that right and it has been extremely careful.

Mr. SCHAEFER. I hope once this has all been taken care of, and your waiver comes through, you will share your information with other people in other areas.

Mr. MCNAMARA. Be happy to.

Mr. SCHAEFER. We have been discussing all morning the hard times that hit Michigan in the 1980's, and certainly have come along since then, and Governor Milliken and Blanchard endorsed and funded the emergency programs to provide the food and shelter to the needy. They also acknowledged the serious public threat to the people who must go without food, shelter, and the tendency of people without insurance to delay getting health care until they get really ill, dangerously ill.

Vern Smith testified people of all ages without health insurance do, in fact, go without the health care. It is understandable, even with the small children getting vaccinated for the various problems that we have.

Do you believe emergency programs since the one originally envisioned by Governors Milliken and Blanchard are needed now to prevent costly and unnecessary illness while we decide what we are going to do nationally?

Mr. MCNAMARA. I think at present, most people who have a need for health care, there is a way. Those that are outside of our program that are outside of regular health care programs end up in the cost of the automobile that gets delivered because of the unique arrangement that Blue Cross, which is a major health provider, has in setting up their charges. That is unfortunate.

I think that it is one of the reasons why we aren't competitive in the automobile business, is because health care charges are so outrageously large and the indigent, the individual that can't be cared for, is taken to a hospital; the hospital runs up the cost.

The hospital sends the cost to Blue Cross, and Blue Cross in turn shares it with the county of Wayne and Ford Motor Company and Chrysler, and all those other people. In the absence of this kind of emergency plan that you have to make these dollars available, in most instances these people are being cared for, but they are being unfairly cared for. There is an unfair cost being shifted to the industry of this area.

Mr. Schaefer. We had the UAW and Chrysler in today, and that was basically a message that came out. So I don't have another one right at this moment.

Mr. McNamara. May I introduce Deborah Scott, who runs this program, and has been doing a tremendous job. She does the work, and I am taking credit for it.

Mr. Schaefer. Mr. Chairman, I yield back.

Mr. Dingell. The Chair thanks the gentleman. The Chair recognizes the gentleman from Michigan, Mr. Upton.

Mr. Upton. Thank you, Mr. Chairman, and thank you, Mr. McNamara, for bringing this to our attention. It certainly sounds like it works and it works well. Both of you are to be commended for the leadership you provided, certainly to this side of the State.

I have a couple of questions. How many providers do you know that actually participate in the program? Do all of them participate?

Mr. McNamara. We took bids and selected four. We have the program basically split up, roughly 10 to 12,000 indigents in each one of these—with each one of these providers. They all agreed to the same $77 per month.

Mr. Upton. But in terms of the hospitals or physicians that might participate in the program——

Mr. McNamara. Deborah tells me we have 190 subcontractors, but four basic providers.

Mr. Upton. You indicated in an earlier question that Pennsylvania apparently has a waiver from HCFA?

Mr. McNamara. It is my understanding they do.

Mr. Upton. Do you know the history, why they have one and why you have not been heard?

Mr. McNamara. No. I know we have run this program in the past with State dollars and county dollars. The State has said they no longer can afford it. Someone came up with the ingenius plan of leveraging the county dollars with Federal dollars to fund the program.

In the course of this, we were told Pennsylvania has been doing it for years, we ought to be able to do it, too. So I don't know if that answers your question. Can you add anything to that, Deb?

Ms. Scott. No.

Mr. Upton. How long has your request been pending?

Mr. McNamara. I would say not more than 30 days. Up until New Year's, we weren't sure the State was going to fund this program. We were in the process of making plans to close it down. We had absolutely no way of funding the health needs of these 43,000 people until someone discovered the Federal leveraging aspect of it.

Mr. Upton. I appreciate your testimony. Thank you for sharing that with the committee.

Mr. Dingell. The Chair thanks the gentleman. The gentleman from Michigan, Mr. Conyers.

Mr. Conyers. Thank you, Mr. Chairman. I am always delighted to see and hear from Ed McNamara, and I congratulate you on this program. You cited bipartisan support that has helped you along the way and out of the hole. Is the Attorney General of the State of Michigan included in that bipartisan support package?

Mr. McNamara. Yeah, I think so. Frank is—hasn't given us——

Mr. Conyers. A good friend of ours, but I have not heard anybody use the Michigan Constitution as a basis for drawing a legal conclusion in many years, many years.

Mr. McNamara. He really hasn't been involved.

Mr. Conyers. Well, he found it unconstitutional.

Mr. McNamara. Well, I think we have worked around that, John.

Mr. Conyers. Not to worry?

Mr. McNamara. Not to worry.

Mr. Conyers. Well, I am glad to hear it. If you are not worried, I am sure not worried. When I read about an Attorney General finding a method that found State legislation unconstitutional, I am worried until I hear from the Chief Executive.

Mr. McNamara. We asked Mike Dugan for——

Mr. Conyers. Bernard Kilpatrick, out in the audience, just assured me to relax, I don't have to pursue this line of questioning.

Mr. McNamara. Mike Dugan's opinion overrode the Attorney General's.

Mr. Conyers. Do these things happen in local government?

Mr. McNamara. Oh, yeah.

Mr. Conyers. It has happened before. Now, this all goes together. You know, we have got to worry about the larger picture. We have got the national picture as well as our State and our city. At $77 a month, what about the heart by-pass case or the person that costs $78 a month or the person that costs $7,700 a month, because that fits in, Mr. Executive, to a larger question.

You serve, and admirably so, 43,000 people in the county through this wonderful program. Three hundred thousand people in Detroit, part of your county, don't have a dime's worth of health insurance. Probably 100,000 more are seriously underinsured and won't know it until the wrong health problem meets the doctor or the hospital that they go to.

So I need you to expand with us the nature of the problem, because you can't mean that most people are being cared for, because the only thing you can get without health insurance in America—this has nothing to do with Detroit or Wayne County—is that you maybe can get some emergency care if you are lucky; that is, you can go to the emergency room at Ford and they will give you some pills or something, but that doesn't have anything to do with treatment.

We are working on a serious problem that we have been in since 1935, when Franklin Delano Roosevelt darn near put national health insurance in the Social Security Act of that year. So I need you to give us this broader picture for which I know you are good for.

Mr. McNamara. One of the things this program initially had, and still does have, is about $5 million that can be drawn on hospitals to do things for those 300,000 you are referring to. What I think this program has done for us is to prove that it is a workable program that will make sense, and that for $70 to $85 a month, we could take care of those people also by getting the providers to extend the same kind of service to those other 300,000, if that is the number.

What we are trying to do now is meet with these health care providers to work out a plan where they—where they will cooperate to provide this service. We would then hope to start picking off employers who presently don't furnish health care insurance or health care of any sort, and involve them in the program.

We think if this was mandatory—for instance, if the State Legislature would make it mandatory that all employers in the County of Wayne had to participate in a cooperative health care plan, that we could actually save those health care—or those employers money with this plan.

Mr. DINGELL. I am trying to understand. The bounds of county care geographically are outside the city of Detroit. In other words, persons within the city of Detroit are not covered under this plan?

Mr. MCNAMARA. Oh, yes. All 43 communities, including Detroit, and the major portion of our 43,000 come from the city of Detroit.

Mr. DINGELL. Thank you.

Mr. MCNAMARA. Probably 80 percent of them.

Mr. CONYERS. Well, in other words, you are advocating a local national health insurance plan.

Mr. MCNAMARA. Absolutely, absolutely. We think it will work.

Mr. CONYERS. I think it will, too, on the national level, as well.

Mr. MCNAMARA. What we would love to do, Congressman, is prove in Wayne County it can work, but we need some legislation and we need some sources—for instance, if we could get a nickel on a pack of cigarettes in Wayne County in the State of Michigan, that would be the government's contribution.

Then we have the State's contribution, and we have the employer's contribution. You put those three together, you can give as good health care as those 43,000 people are getting today, and we get very, very few letters from those 43,000 complaining about health care, because there is an incentive for that health care provider to take care of that person. It pays them to go out and look for them and find them and say, hey, you have high blood pressure; we will give you a prescription to take care of it. They don't want them coming back as a stroke victim because they only get $77 a month, regardless.

Mr. CONYERS. What part of your 43,000 are indigent, what part are Medicaid, what part are Medicare, what part are private insurance?

Ms. SCOTT. All of the county care recipients are indigent patients between the age of 21 through 64. Medicaid is a different program. This is one category, medical indigents in Wayne County.

Mr. CONYERS. No Medicaid, no Medicare, no private.

Ms. SCOTT. Absolutely.

Mr. CONYERS. You are dealing with the most medically underserved population in the city, the county, or the State.

Mr. MCNAMARA. Correct.

Mr. CONYERS. Now, this becomes a program that needs to be extolled. If you can provide them adequate care for $77 a month, I need to be paying you a visit very, very shortly. But I thank you, Mr. Chairman.

Mr. Dingell. The Chair thanks the gentleman. Mr. McNamara, we have talked briefly about your waiver at HHS. You told my colleagues that it was filed about 30 days ago?

Mr. McNamara. I would estimate 30 days. It may be less than that, Congressman. I have a meeting with the State Treasurer on Tuesday to discuss some of the problems, apparently, that this has run into. I really can't comment on it. I don't have any detail, other than to know it does involve a waiver that we have never asked for before.

Mr. Dingell. You and I have a very long and happy history of working together on problems. I think the committee would like to interest itself in your waiver and encourage a pattern of right thinking at HHS. Can you give us a little appreciation of what would happen if you don't get the waiver?

Mr. McNamara. The County of Wayne puts about $15 million, I believe, into this program. That is what we put in last year, and that is what we plan to put in this year. Even with that, we were creating a reserve in case those 43 became 48,000, we didn't feel a need we had to go back to the State or increase our contribution.

In the event this falls apart, this program would have to be phased out. The County of Wayne—we say we balanced a $180 million budget; we balanced it with $120,000 in the black at the end of the year, so we really don't have any bucks to put into this program.

In the event the waiver dies, the whole program will die. It will be dismantled. As we told the Governor and the Legislature, we will be talking about body counts shortly after that.

Mr. Dingell. How much longer can they continue to support this program?

Mr. McNamara. 30 days.

Mr. Dingell. Do you have any problems in connection with this on the part of the suppliers, with possible liability for malpractice, or anything of that kind?

Mr. McNamara. Us?

Mr. Dingell. Is there a potential for a malpractice problem?

Mr. McNamara. We have not had that problem. Of course, we have a provider that stands between us and the patient.

Mr. Dingell. I am aware of that, but does the provider have any problems you are aware of?

Mr. McNamara. To our knowledge, none. We have other providers that would like to get into the plan.

Mr. Dingell. The Chair recognizes the good friend from Colorado.

Mr. Schaefer. What about AIDS patients? Do you handle those?

Ms. Scott. AIDS patients are eligible for county care until a point in time in their illness when they are deemed disabled by the State of Michigan. At that point, there is a process to transfer them to the Medicaid disability program. We take care of them as soon as they are HIV-positive and for some part, sometimes more than we feel we need to take care of them during the disease process itself. Once they are disabled, unable to work or will be dead in a year or less, they are to be transferred to the Medicaid disability program.

Mr. Schaefer. Where would that be? Transferred——

Ms. SCOTT. It is a process that occurs—the hospital helps fill out an application or the patient can go to the Department of Social Services and the paperwork is completed by the workers, doctors, physicians caring for the patient. It is sent to the State, the State evaluates it and determines whether or not that patient is eligible for Medicaid due to their disability.

Mr. SCHAEFER. This has been worked out with your providers, as far as having no problems with AIDS patients.

Ms. SCOTT. This is a standard process that existed before county care. This is something we have educated the provider network regarding how to do this and how to do it the quickest way possible. It is a process we would like to improve, in some cases, but for the most part, that is how it happens.

Mr. SCHAEFER. One other question. You testified, Mr. McNamara, the larger portion of indigents are in Wayne County, when you look at the whole State. What about—and I kind of asked the question, but Mr. Conyers hit it.

OK, we have a national health care plan, but it is really within the county. Would you adopt this same thing in some of the other—Lansing or Ann Arbor or where some of the other gentlemen are, even though they have a smaller portion?

Mr. MCNAMARA. I think it would work as well. Again, I think if you take some of the counties in Michigan, Schoolcraft County might have two indigents; Washtenaw, an indigent is a kid that only has two bicycles.

Mr. SCHAEFER. I understand. We are not talking about the four or five. You said—how many percent was in Wayne County?

Mr. MCNAMARA. I would say probably 50 percent.

Mr. SCHAEFER. You are taking that other—I don't know what is in Lansing or Ann Arbor.

Mr. MCNAMARA. Saginaw, some of the counties—Flint would have some where this program would work well. Perhaps Grand Rapids, Congressman can't.

Ms. SCOTT. It is proposed in the new legislation that any county choosing to set up a model such as what we have done in Wayne County has that opportunity. Genesee County has expressed an interest, and we are currently educating some of the administration there as to how they could do it.

Being a managed care program, it is important that you have at least 10,000 recipients. Mr. Conyers asked about the $77, how does that work? Some people never show up and the provider still gets that $77. Some people show up and will utilize maybe $10,000. They take theirs and a whole lot of other people's $77.

The concept is, there have to be enough people nationwide, and according to the professional, it needs to be at least 10,000 people for that to work. We do consider ourselves a model. We can be duplicated in the State, in other counties or as a national model, of course with adjustments that need to be made according to the locale and the different needs in that area.

Mr. DINGELL. The Chair thanks the gentleman. Mr. McNamara, it has been a privilege having you here before us. Good to see you again as a personal friend. We are always delighted to see an old friend like yourself today.

Mr. CONYERS. We won't ask about the baseball stadium.

Mr. Dingell. Ms. Scott, we thank you for your assistance here, too. You are doing remarkable work.

Mr. Dingell. The Chair announces, to the vast surprise of all including the Chair, we are proceeding on schedule. The Chair announces that our next panel is a panel composed of Ms. Susan McParland, staff attorney, Michigan Legal Services; Dr. David Adamany, president, Wayne State University; Mr. James Foster, administrator, Three Rivers Area Hospital, St. Joseph County.

Ladies and gentlemen, we are deeply appreciative of your being with us, and thank you for your assistance. To you, Dr. Adamany, we want to express our particular thanks for your hospitality today and making available to us the services of the university. You and your staff have been of extraordinary assistance to us, and we thank you.

We will start with Ms. McParland. We thank you for being with us.

STATEMENTS OF SUSAN K. McPARLAND, STAFF ATTORNEY, MICHIGAN LEGAL SERVICES; DAVID ADAMANY, PRESIDENT, WAYNE STATE UNIVERSITY; AND JAMES R. FOSTER, ADMINISTRATOR, THREE RIVERS AREA HOSPITAL, ST. JOSEPH COUNTY, MICHIGAN, ACCOMPANIED BY ROBERT McDONOUGH, BOARD MEMBER

Ms. McParland. Thank you very much, Chairman Dingell, for this opportunity. I am Susan McParland. I am staff attorney at Michigan Legal Services here in the city of Detroit. I wanted to thank the committee for the opportunity to testify and to submit a written statement on issues of such enormous importance to the poor and disabled citizens in Michigan.

Our office, I would like to say, is uniquely suited to discuss the details of the budget cuts in human assistance programs in Michigan and to relate the consequences of those cuts for hundreds of thousands of residents. Our role is lead counsel in virtually every lawsuit filed in 1991 and now in 1992, challenging the reductions in the budget for Michigan Department of Social Services, gives us a singular perspective, and as counsel for plaintiffs in plaintiff classes, we have, of course, very detailed knowledge concerning the effects of these cutbacks on those individuals.

The theme of my testimony is that the health care needs of Michigan's impoverished, disabled, elderly and young are not being met in the present circumstances in which benefits, emergency assistance, and State medical care reductions result in deprivation of basic needs, including important health care needs.

Contrary to some of the prior speakers, I would like to point out that the health care needs around this State are not being met, not only because the basic health care programs are not providing those services, but also because you cannot view health care in isolation. The inevitable consequences of long-term deprivation of this nature and degree poses a threat to the public health and welfare when the enormity of the reductions and their effect on low-income people is weighed and the full implications considered.

A compelling basis exists for stating that a human emergency exists in this State. Contrary to myth, the emergency is not limited by geography, age, race, or gender. And in a recessionary time, the wisdom of drastically cutting back on human services is highly doubtful.

Moreover, the established health care systems, like Medicaid, cannot possibly address the crisis in physical and mental health effectively when thousands of Michigan citizens are facing homelessness and destitution. More specifically, hundreds of elderly disabled are being forced to stretch their prescription medication because the State medical care programs fail to provide adequate payment for those medications.

Executive McNamara discussed the highlights and good points of the Wayne County care system, and I would just like to add, although that is a very laudable program, that is limited to Wayne County. All throughout the rest of Michigan, indigents who are not receiving cash assistance are receiving very, very limited medical care.

Far from being anecdotal, the scores of declarations which we have collected throughout our lawsuits, many of which I have included in attachments to our written statement, which depict the horrors experienced by the poor and disabled during the last year, these are representative, not anecdotes, and they represent the crises and abuses being heaped on the most vulnerable in this State. These stories are a vivid and accurate illustration of the ways in which the policy changes in cutbacks are affecting Michigan's poor, and sadly, they are not anomalous.

My written statement includes a great deal of detail describing the reductions in welfare programs, policy changes and descriptions of the litigation and policy advocacy our officers and others have undertaken in the past year to ameliorate the harm. Here, I would like to describe the current affairs in terms of the assistance programs in Michigan and how they are affecting—those cuts are affecting some specific individuals.

Yesterday, February 27, our office filed a lawsuit—another lawsuit against the State on behalf of several classes of individuals, challenging the restrictions and procedural barriers in three very critical State-funded programs in Michigan; those include the State Disability Assistance Program, the Emergency Assistance Program, and Indigent Medical Care.

The State Disability Assistance Program, which was created in October of 1991 to provide continuing care for disabled people, is serving only 7,500 people in this State at present, whereas as many as 40,000 or 50,000 are potentially eligible, but because of procedural barriers, and a rigid definition of disability, those people are not receiving cash assistance.

Many people here, especially from Michigan, are probably familiar with the story of the woman who was featured in a Free Press editorial a couple of weeks ago, who was turned down for the SBA program and told that her blood pressure was quote "not high enough to qualify." Two weeks later, she suffered a stroke and was hospitalized. Following being featured in the Free Press editorial and named in our lawsuit, she was finally qualified as eligible for SBA benefits.

Similarly, Ms. Victoria Goad, whose affidavit is also included in the attachments, is a 61-year-old woman who suffers from hypertension, diabetes, uterine tumors and a variety of other ailments. She has waited over 5 months to qualify for SDA. During that period, she has been without any assistance. It is only after testifying in the Michigan State legislature and being named as a plaintiff in our lawsuit that she was qualified for SDA benefits.

The stories go on and on in the Emergency Assistance Program, which is a joint Federal-State program designed to provide assistance to low-income persons facing emergencies ranging from delinquent health payments to utility payments, to prevent termination of utility services.

The State's recent—and by recent, I mean December of 1991—revisions in this program result in the virtual exclusion of every applicant, and benefits so low that the emergency they are facing cannot possibly be addressed.

I would like to give the committee one example, the case of Robin Esse, whose declaration is also included in the written materials. Ms. Esse is 35 years old. She suffers from life-threatening diabetes and very severe depression, so severe she has been hospitalized numerous times for suicide attempts.

She receives $425 per month in side benefits. Despite the fact that she pays a modest rent amount of $200 per month, she can no longer qualify for any emergency assistance from the State of Michigan to help pay a delinquent water bill because her rent exceeds $160 per month, which is the maximum allowable rate for an individual in Michigan to qualify for emergency assistance.

That policy obviously has an impact on her, and thousands of other people whose rent obviously exceeds $160 per month. The changes in the emergency needs program which I have included in great detail in the written statement on these changes virtually precludes thousands and thousands of people from desperately needed emergency assistance.

The third program, the indigent medical care program, is a State-funded program that previously provided indigent medical care to general assistance recipients in this State. The current structure of that program is a two-tiered structure, and if an indigent person is not receiving a cash assistance benefit, that is, eligible for the SDA program or family assistance, they are only eligible for a very limited medical care.

So in the case of two of our named plaintiffs in the lawsuit we filed yesterday, Vernon and Mary Faircloth, they are not eligible for SDA despite suffering from numerous ailments. They have waited for 6 or 7 months to have their application turned down, and they both require numerous medications each month.

They have to pay a copayment for those medications under this medical care system of $14 per month, out of zero income. They have been told by their worker that they ought to collect pop bottles to raise the amount. Every month since October they have gone to local charities and churches to raise the money. So far, they have been successful doing that. However, obviously that places enormous stress on them.

Further, the case of Eva Fredericks, and I think if anything points out the disparity between health care delivery, this case does, and this also illustrates how people out of State are not being served. Their medical needs are not being served and not being absorbed, because there are so few number of indigent people out of State, not being absorbed by the mainstream medical system.

I am sure many people are familiar with Ms. Fredericks. She is the woman who skipped her heart medication following the cuts of October 1st last year, because she knew the following month the State would not be paying for it. She suffered a stroke as a result of this, and died several weeks later.

These are the sorts of horrors that are resulting directly, not indirectly, but very directly, from the reductions in these programs and the scope of services. Although litigation and advocacy may resolve some issues in these programs and some of the problems, it is clear by now that those measures cannot ameliorate the widespread emergency in this State.

It is also crystal clear that private agencies and charities, contrary to the assertion of the administration in this State, cannot fill the gap. In the short term, there has to be a way that the Federal Government can address delivery of emergency relief to this State.

Also, I have discussed the issue of the enforcement of the Medicare Catastrophic Act and the 1988 rollback provision in my papers. It is clear that the State of Michigan is benefiting from very large sums of Federal match money in the Medicaid program. However, I think it is inappropriate for the State to come to this committee with a wish list for Medicaid enhancements when they were not willing to pay and to support the basic human services programs in this State, without which the health of thousands of people in this State is undermined.

Those are the sorts of things I would recommend, and I thank you for the opportunity to testify, and I welcome any questions.

[Testimony resumes on p. 230.]

[The prepared statement and attachments of Ms. McParland follow:]

Testimony Submitted By
Susan K. McParland
Staff Attorney
Michigan Legal Services
Detroit, Michigan

- to -

Subcommittee on Oversight and Investigation
of the Committee on Energy and Commerce

February 28, 1992

Michigan Legal Services is the state support center for legal services in Michigan. Our office addresses issues affecting low-income persons on a statewide basis through class-wide litigation, policy advocacy, legislative representation and assistance to local or neighborhood legal services programs. We believe that constant communication with legal services advocates and policy makers has always given us a good sense of problems in access to adequate health care, and adequate government benefits and other emergency assistance programs.

Our role as sole or lead counsel to plaintiffs and plaintiff classes in virtually every lawsuit filed during 1991 and 1992 challenging budget cuts in essential human services in the State of Michigan Department of Social Services makes our program uniquely suited to discuss the details of the reductions in assistance programs, the impact of the reductions in programs already underway, and the likely impact of the reductions if the situation continues unabated.

In response to the Sub-Committee's invitation, I prepared testimony and a written statement addressing the question of the consequences of the State of Michigan's welfare cuts on the ability to provide health care through established programs, such as Medicaid and impact of the reductions on the public's health and safety resulting from the lack of adequate housing, utilities, food, and other essential services. It is in the context of the latter inquiry that the full implications for public health and welfare and the threats posed to the physical and mental well-being of hundreds of thousands of residents is clarified. The immediate consequences of these reductions presents a compelling basis for stating that a human emergency exists in the State of Michigan, nevermind the inevitable effects of long-term deprivation on significant numbers of persons many of whom are extremely fragile, physically or mentally disabled, or very old or very young.

I also wish to pass on the observation that the policies resulting in reductions in welfare benefits and emergency assistance in Michigan differ from other recent welfare reforms or cutbacks in this state or in the federal government. There is a mean-spiritedness in motivating these policy decisions which is especially shocking in a state like Michigan which has such a fine midwestern tradition of providing human services to its poor and temporarily disadvantaged citizens.

To substantiate these allegations, I have included in the attachments to this statement, a number, although a small fraction of declarations of plaintiffs and or class members in various lawsuits who are directly affected by cuts in cash assistance, emergency assistance or medical assistance programs. (Declarations "A").

Responses to many of the very specific questions raised by the committee concerning aspects of Michigan's Medicaid state plan are included also in this written statement.

The theme of my testimony is that health care needs cannot be met under the circumstances in existence in this State where essential services are not being provided to hundreds of thousands of the State's poorest and most vulnerable residents.

Assistance programs were established and exist to address the needs of low-income or impoverished individuals and families whenever they arise. Secondly, welfare programs serve a related function by expanding to prevent disaster to individuals and families when an economic downturn reduces employment. Historically, the welfare rolls rise as unemployment increases suggesting that human services should be increased not decreased in a recessionary economy. The fact that Michigan's administration chose to drastically reduce basic and emergency assistance programs during an economic downturn greatly exacerbates the dilemma faced by poor persons, the elderly, and persons with disabilities and the unemployed in this State.

BUDGET CUTS UNDERTAKEN BEGINNING IN JANUARY, 1991, ACTIONS TAKEN BY MLS AND, IMPACT OF THOSE CUTS ON THE POOR IN MICHIGAN

In January, 1991, the Department of Social Services began developing its proposed cutback plans in response to the Legislature's recent enactment of a supplemental appropriation which provided in part for 9.2% annualized reduction in spending. 1990 PA 357. Although it was clear by the fall of 1990 that the State of Michigan had a large budget deficit, the newly elected Governor's response to the deficit included plans which reduced DSS' budget disproportionately and resulted in permanent restructuring of the eligibility criteria for benefit programs, covered services and the elimination of many programs and services.

The Director of DSS' initial plan for cutbacks was rejected by the House Appropriations Committee triggering the so-called automatic line item reductions provision in PA 357. Contrary to assertions that DSS' plans for implementation of the reductions were even-handed, the plans finally put in place reduced benefits and services disproportionately and eliminated some services altogether. A few examples follow:

- Elimination of the Licensing and Regulation Division with responsibility for regulating and licensing day care centers and in-home child care arrangements; and sole responsibility for investigating allegations of child abuse and neglect occurring at child care centers. (Restored after litigation was filed).

- Rateable reductions of 17% in AFDC and General Assistance payments, and approximately 40% in SSI state supplements.

- Complete elimination of Chore Services for the adult Home Help unit for the elderly and disabled.

- Restriction of durable medical equipment including wheelchairs and prosthetic devices to individuals who need the equipment to prevent death or immediate institutionalization.

- Reduction in contract funds to emergency food providers and emergency shelter providers.

- Reductions in several emergency needs benefits and complete elimination of payment for delinquent water and sewerage bills.

- A ratable reduction of 13.4% in benefits to participants in Job Start reducing their benefits from $253 per month to $219.

In February, 1991, MLS along with the United Auto Workers (UAW), Michigan Association for the Educations of Young Children (MAEYC), Westside Mothers, Capuchin Soup Kitchen and Michigan Fair Budget Coalition, filed suit challenging the constitutionality of the statutory provision which mandates the reductions and the proposals developed by DSS implementing the cuts. Plaintiffs alleged that the provisions and actions taken by DSS to implement the provisions constituted an unlawful delegation of legislative authority to the executive departments to develop plans to implement the cuts. Plaintiffs alleged Defendants' proposals violated various federal and other state laws. Michigan Education Association for the Education of Young Children, et al. v State of Michigan, et al. Wayne County Circuit Court, No. 91-104221-CL.

The harm showed by the plaintiffs at trial included the following:

- 32,000 households lost vendor shelter on 3/1/91 because not enough left in their grants after 17% cuts. With an average household size of three for AFDC households, translates to 90,000 persons losing all income. In addition, many others who were not vendoring, did not receive enough to pay for shelter after cuts,they too would lose housing. Locating replacement housing would be very difficult since most landlords who rent to low income families were already charging the maximum that DSS would pay.

- In addition to shelter vendor terminations, 6000 utility vendor termsinations. Utility vendoring gives shut-off protection. So 6,000 were losing shut-off protection.

- Loss of discretionary income - no money to pay for doctor travel, etc.

- For every ten dollar ($10) increase in cash benefits, there is a $3 increase in FS benefits. Thus a reduction in ability to purchase food.

- Psychological harm to thousands who would be living in fear of becoming homeless and destitute.

During the preliminary injunction hearing in the Wayne County Circuit Court, plaintiffs presented enormously detailed in-court testimony, affidavits, and documents from clients, emergency providers and experts demonstrating the probable consequences of the cuts as listed above.

The Wayne Circuit Court Judge issued a decision denying Plaintiff's Motion for

Preliminary Injunction on March 28, 1991 -- some of those claims are on appeal, however, many of the Separation of Powers claims were resolved favorably in later litigation between the Speaker of the House and Governor Engler. See infra.[1]

BABBITT/CAMPBELL LITIGATION

In late April of 1991, a lawsuit was filed on behalf of a class of AFDC recipients and OBRA/Qualified Medicare Beneficiaries (QMB) recipients in the United States District Court for the Western District of Michigan challenging the State of Michigan's failure to pay AFDC benefits at the levels in effect in May of 1988 as a violation of the Medicare Catastrophic Act, 42 USC §1396a(e) (MCCA). Plaintiffs challenged also the elimination of Medicaid coverage for OBRA/QMB beneficiaries.[2]

The District Court entered a temporary restraining order enjoining the State from reducing its AFDC benefit levels below those in effect in May of 1988.[3] However, the Court denied Plaintiffs-class' request for preliminary injunction and held that the MCCA prohibited only those reductions in AFDC levels made for the explicit purpose of paying for increased Medicaid costs. The decision is on appeal.

Meanwhile, MLS filed a lawsuit on behalf of plaintiff class of AFDC recipients and former recipients of OBRA/QMB as a related case to Babbitt in which plaintiffs are challenging

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[1] The cuts were implemented in March, 1991 and Plaintiffs' fears were realized as the number of evictions soared, etc.

[2] Babbitt v Michigan, No. 4:91-CV-56 (W.D.Mich.) final decisions from District Court October 29, 1991. On appeal to the Sixth Circuit Court of Appeals.

[3] In May, 1991, Michigan was paying AFDC benefits approximately 15% below the levels in effect in May, 1988.

HHS' authority to approve of Michigan's Medicaid plan amendments when the State is paying AFDC benefits at a level below those in effect in May, 1988. That case is pending.[4]

The State of Michigan continues to pay AFDC benefits at a substantially reduced rate, and despite two recent adjustments, AFDC benefit levels in January, 1992 were 13% lower than the benefits paid to recipients in January, 1991. **(See Generally, Center on Budget and Policy Priorities, The States and the Poor, How Budget Decisions in 1991 Affected Low Income People).** There are approximately 650,000 AFDC recipients in Michigan -- the reductions in grant amounts means that those families are living at approximately 56% of the poverty level.

SAXON V *MILLER*

In April, 1991, DSS announced that it would no longer pay delinquent water and sewerage bills under its Emergency Needs Program for renters and homeowners. Under long-time policy and detailed rules defining the ENP program, DSS paid for all utilities, including water if the claimants met the eligibility criteria and were facing an emergency as defined in statute and rules.

In May, 1991, MLS filed suit on behalf of a class of plaintiffs eligible for ENP services for delinquent water bills, but for the policy change; and was claimed that the policy change which was adopted by administrative fiat violated the Michigan Administrative Procedures Act.[5] A temporary restraining order was entered was entered on May 17, 1991 and plaintiffs presented proofs at an evidentiary hearing for preliminary injunction in June. The proofs demonstrated that irreparable harm was occurring to plaintiffs living without water or facing interruption of services. At that time, thousands of Michigan residents were facing termination of water service. Several named plaintiffs had survived without water services for up to several weeks, relying on neighbors or the local fire department to fill up pop bottles for them in an attempt to meet their sanitation and hygiene needs. The affidavit of Jane Doe included in the attachments demonstrates graphically the harm incurred by plaintiffs. (Attached "A").

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[4] In a similar lawsuit, the U.S. District Court in Massachusetts issued an opinion declaring that the State's reduction of AFDC benefits levels below those in effect in May, 1988, violates MCCA. Avanzato v HHS, et al., No. 91-30205-F.

[5] Saxon, et al. v Miller, et al, No. 91-69009-AZ, Ingham Circuit Court.

Testimony from experts, including Dr. Myron Wegman, M.D., substantiated plaintiffs' claims that lack of adequate water supply posed a threat to the health of the individuals directly affected and potentially the general public.

The court continued the TRO in effect pending a ruling on Plaintiffs' Motion for Preliminary Injunction. DSS rescinded its policy for non-payment of water bills in July, 1991.

STATE ADMINISTRATIVE BOARD TRANSFERS

In May, 1991, Governor Engler convened a meeting of the State Administrative Board to approve resolutions for transfer of appropriations between line items, including a resolution to move funds out of the line item for General Assistance benefits and into account for SSI supplements, Medicaid, etc. DSS immediately began implementing plans for termination of the GA program and sent notices to clients at the end of May that all GA benefits were ending effective June 1, 1991.

Several members of the Legislature filed suit against the Governor and the State Administrative Board challenging the proposed transfers as unconstitutional and in violation of the Separations of Powers clause of the Michigan Constitution.[6] Although the lower court denied the plaintiffs' request for relief the Court of Appeals issued a preliminary injunction enjoining the transfers.

Meanwhile, plaintiffs in Saxon filed an amended complaint on behalf of GA recipients threatened with termination of all cash assistance on June 1st. Because of the injunction in Dodak, plaintiffs did not have to pursue their claims concerning termination of the GA program.

1990 PA 68 SUPPLEMENTAL APPROPRIATIONS

The Legislature and Governor reached an agreement on June 16th providing supplemental appropriations for the AFDC program, families receiving GA and various other line items, including Medicaid and foster care. Benefit levels for AFDC and family GA were increased by 8.50%, resulting in a ratable reduction of 8.5%. However, GA payments for single GA recipients were reduced an additional 12%, for a total reduction of 29%, resulting in benefit levels of approximately $170.00 per month to GA recipients. Recipients of GA who could prove they were disabled would be spared the additional 12% reduction. Since no determination of disability had been made for any GA recipient, disabled recipients who eventually proved their disability would have to wait to receive supplement some time in the future.

The GA program, the implementation of the disability supplement, and the Executive's proposal for further reductions in the Medicaid program, the Emergency Assistance program and the state funded indigent medical care become the centerpiece of discussions for the 1992 budget.

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[6] Dodak, et al. Engler, et al., Ingham County Circuit Court, No. 91-68942-CZ; Court of Appeals decision, reporter 190 MA 260 (1991).

The huge reduction in the amount of GA grants had already proved devastating for GA recipients, especially disabled and older recipients who could not even pay their rental obligation out of the monthly benefits. Data from emergency providers including temporary shelters and soup kitchens continued to show that thos agencies could not meet the increasing need of Michigan's poor. **(See generally, More Water in the Soup, Michigan League for Human Services, Attached B).**

1991 PA 111; AND SAXON V MILLER CHALLENGING FAILURE TO PAY BENEFITS TO DISABLED GA RECIPIENTS AND ELIMINATION OF EMERGENCY NEEDS BENEFITS AND INDIGENT MEDICAL CARE

The Legislature enacted the appropriation for DSS for fiscal year 1992 on September 28, 1991. The budget which was passed consisted essentially of the Governor's proposals for DSS. The main provisions of PA 111 are as follows:

- Elimination of all funding for GA for single adults and married adults without children.
- Creation of a State Disability Assistance Program for several categories of disabled persons, the most significant of which, "is a person who is medically diagnosed as incapacitated and unavailable for work for at least 90 days".
- Elimination of the Emergency Needs Program and distribution of limited funds to the counties in the form of block grants to use for emergencies with no guidance from the State.
- Elimination of the Indigent Medical Care Program and distribution of limited funds to the counties in the form of block grants to use for indigent medical care with no guidance from the state.

On October 2, 1991, MLS filed a Supplemental Complaint on behalf of a class of former GA recipients who were entitled to receive continued assistance because they are disabled. Plaintiffs alleged that DSS violated their right to constitutional due process in that they were not given adequate notice of the termination of GA benefits, the criteria for the disability assistance program, and were deprived of aid pending evaluation of their eligibility for SDA.

During the preliminary injunction hearing plaintiffs produced incredible proofs of the harm occurring to class members who although severely disabled were without any source of income. Some of the declarations admitted into evidence are included in the attachments. The declarations provide graphic illustration of the deficiencies in the program, which deprives aid to people in such obvious need.

Here are some examples from October, 1991 when the cuts had just occurred:

- person seriously injured in a car accident,living without gas and under notice of eviction,
- person suffering from polio, asthma,and diabetes, living in an apartment with no heat, water, or electricity, and unable to pay for medication,
- sixty-year old person living in a shelter following hospital release for emphysema, and hypertension,
- 56 year old resident of adult foster care home recuperating from heart surgery, suffering from severe emphysema, unable to pay for himself, and out of medications.

The trial court in a lengthy opinion granting preliminary injunction, to plaintiffs described the enormous harm to plaintiffs unfolding within the 2 weeks following termination of benefits:

> The fact that the foregoing people are not qualified for benefits is only part of the story. The "rest of the story" is filled with chapters about people who may lose their homes, people forced

> from their apartments, who cannot pay utilities or purchase medicine. This story is also about people whose families have been ruptured, whose privacy has been taken away, people who must sleep on the linoleum floors of noisy and overcrowded shelters, and who have been subjected to a host of other indignities. The assertions of immediate and irreparable harm are established beyond question.
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> * * * *
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> Of the cases considered by this court, it is difficult to think of an instance in which granting the requested injunctive relief is more clearly in the public interest. Granting this relief would ameliorate, at least in part, some of the unjustified suffering brought about through the unlawful termination of those benefits by the Department. It would permit some of these people to remain in their homes, remain with their families, pay their utilities and reestablish at least a semblance of normality in their lives.
>
> In addition, granting injunctive relief here will permit the DSS to put into place a mechanism for identifying those persons who do qualify for disability payments. It will to some extent help restore confidence in the ability of the DSS and ultimately the State of Michigan to address the important social problems which now confront the people of this State. Slip Op. Saxon v Miller. Id.

Although, the trial court ordered DSS to establish a plan for identifying disabled people and to pay benefits pending evaluations of eligibility, DSS filed an emergency appeal and the Court of Appeals issued a stay of the preliminary injunction. The preliminary injunction was reversed by the Court of Appeals on November 11, 1991 and leave to appeal to the Michigan Supreme Court was denied.

Despite enormous public outcry and hearings in the Legislature inquiring into the practices in the SDA program, DSS' lawless practices which deprive thousands of eligible former recipients of desperately needed assistance continue. In fact, only approximately 3,000 additional persons have been determined eligible for SDA since its inception October 1st.[7]

The principal reasons for the shockingly low number of SDA recipients are found in the practices employed by DSS and the rigid and narrow definition of disability being employed by DSS despite the broadly written statutory definition of disability.

Studies of the GA population undertaken prior to the cessation of the program show that as many as 40,000-50,000 former recipients suffer from disabilities or other impairments which may qualify them for SDA; (studies attached "E"), yet only 7,500 individuals are receiving SDA benefits.

STATUS OF RESTRICTIONS AND REDUCTIONS IN ASSISTANCE PROGRAMS

The restrictions on access to assistance programs and drastic reductions in scope of services and amount of benefits for poor persons, have as a result of recent actions taken by DSS become more severe. What follows is a discussion of the current reductions in assistance programs in Michigan, and consequences of those cutbacks for the poor in Michigan.

SDA Program

The problems with misclassification of disabled people not only arose in the transitional period but obviously continue.

The Detroit Free Press reported on February 7, 1992 " the plight of a 58 year old Oakland County woman' who had a stroke January 25, 1992. The divorced woman had once been a nursing assistant, but because of a strained back, high blood pressure, and arthritis, was supported by General Assistance benefits until the program was narrowed to eliminate the nondisabled October 1st. Her doctor filled out a form for the new Disability Assistance program. The newspaper continued, "But without laying eyes on her, the bureaucracy turned her down at the end of November. At a review two weeks later, a medical social worker said her blood pressure wasn't that high." This woman is now out of the hospital, but in need of physical therapy. She only after very recently after being named as a plaintiff in a proposed lawsuit was determined eligible for SDA benefits. (Editorial attached). Another 61 year old woman suffering from angina pectoris, arthereosclerotisic, heart disease, duodenal ulcer, esophagitis, diabetes, and uterine tumors, waited five months to be determined eligible despite her doctor's letter to DSS in October stating that she is disabled.

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[7] Forty-five hundred (4500) Medicaid eligible recipients were automatically transferred to the SDA program in october, 1991 - thus only 3,000 additional disabled individuals have been identified by DSS in five months.

A 49 year old woman suffering from bipolar disorder, severe osteoarthritis, and ruptured disc, applied for benefits in September 1991 and still has not received a decision in her case. Her doctors submitted the requested forms stating she is unemployable several months ago.

Some of the most extraordinary evidence came from private attoreys hired by hospitals to secure Medicaid coverage for patients. These attorneys reported to the Michigan Legislature in October, 1991 that many seriously ill clients of theirs had been terminted from General Assistance on the grounds that they were "able bodied", including a 56 year old resident of an adult foster care home recuperating from heart surgery, suffering from severe emphysema, unable to care for himself, and out of medications. A copy of that letter is attached (Med Law Associates Letter to Rep. David Hollister "C").

We continue to observe that many persone who are in fact severly disabled do not receive benefits because of administrative barriers which include:

- As staff is reduced, and existing staff overwhelmed by crises generated by benefit cutoffs, many people seeking help will simply not be seen.
- Medical evidence is hard to obtain, especially when the same will not provide for medical care for General Assistance recipients.
- The experience in Michigan at this point is that doctors who do complete forms frequently fill them out inadequately, and agency workers, who are under an obligation to assist in gathering medical evidence, do not in fact provide assistance.

Testimony and discovery in litigation has established that standards by decision makers vary enormously, and that persons are found not disabled even if there is no possible available job that they could fill. According to policy, agency workers do not take into consideration age, training, or experience. The statewide disallowance rate for SDA continues to be a shockingly high rate of 75%.

THE EMERGENCY NEEDS PROGRAM

The Emergency Need Program is a joint federal-state program providing benefits to eligible applicants facing an emergency as defined in rules and who need one or more of a wide range of services, including utilities, shelter, property taxes and various other essential services.

The Legislature enacted a supplemental appropriation for the Emergency needs Program and Indigent Medical Care Program (SMP) on November 21, 1991 which provided funds for those porgrams and reconstituted ENP and SMP as single-state agency programs. 1991 PA 139.

Despite the supplemental funds, DSS issued emergency rules redefinng the ENP program and renaming it the State Emergency Relief Program. The so-called new program consists of dramatic revisions in eligibility requirements for emergency assistance, so drastic as to preclude virtually all applicants from receiving emergency benefits.

In addition, the scope and amount of services are so restricted that issuance of emergency assistance is unlikely to ameliorate important emergencies. A few exampless of the drastic reductions follow:

- excluding services,
- limiting grants of service,
- imposing ceilings on the dollar amount of services that may be provided within a single fiscal year, ten year period, and a lifetime,
- creating client contribution amounts which exceed the amount in the client's grant for the service,
- assuming contributions from persons who have no income,
- arbitrarily excluding from relocation assistance, certain homeless persons,
- eliminating secirity deposit payments,
- imposing requirements on eligibility for assistance, including the affordable housing rule, which preculded assistance for applicants whose housing costs exceed teh lower of $160 for single persons or 70% of their monthly income,
- requiring all applicants to demonstrate that they have a montly income of at least $165.00.

The restrictions on eligibility and amount of benefits are resulting in enormous hardship to the poor in Michigan, who are no longer receiving assistance with shelter or utilities. One example of a 35 year old SSI recipient illustrates dramatically the impact of the reductions in ENP on the poor and persons with disabilities. (Attached Declaration A). Ms."S" suffers from insulin dependent diabetes, ketoacidosis diabetes, and chronic depression so severe she has been hospitalized numerous times following suicide attempts. Her diabetic condition is life-threatening and requires hospitalization and constant monitoring. Despite her relatively low monthly rent of $200.00, she cannot obtain emergency assistance to help pay her deliquent water bill because of the housing affordability policy which precludes eligibility for individuals whose rent exceeds $160.00.

We are aware of hundreds of persons in desperate need of emergency assistnce for rent and utilities who are daily being turned away from DSS offices. The most outrageous expamples include homeless, indigent persons who cannnot get assistance to pay any rent or shleter costs.

The patent absurdity of the emergency assistance rules is reminescent of the law review article discussing the maze of bureaucracy in the New York City Welfare Department. The article is titled, Charles Dickens Meets Franz Kafka; sadly it is an apt analogy to the present structure of emergency programs in Michigan. Anna Lou Dehovenon, 17 New York University. Rev. of Law and Social Change 231.

MEDICAID AND INDIGENT MEDICAL CARE

Direct health care programs have not fared any better than cash assistance and emergency needs programs in Michigan. In fact, during October and November, 1991, there was no indigent medical care, with the limited exception of payment for life-sustaining prescriptions.

The case of Eva Fredericks, the Copemish resident, who stretched her heart medications resulting in a stroke and later her death is widely known. There are thousands of cases where persons in need of medical care are deprived of that care. (See attached affidavits of Vernon and Mary Faircloth, A).

The state is operating a two-tier medical program , at present, which provides very limited health to poor persons who are not receiving SDA or family assistance. The attached chart distributed by Gerald Miller at a February 6, 1992 hearing shows the disparities in indigent health care. (Attachment D).

Following are responses to the Committee's specific questions regarding Michigan's health coverage and Medicaid State Plan:

1. Which of the many Congressionally-mandated expansions to the Medicaid program has Michigan implemented?

Michigan has expanded pregnancy benefits and children's benefits to federal maximums. Michigan has implemented benefits to Qualified Medicare Beneficiaries. Michigan has expanded benefits to community spouses of nursing home residents, at federal minimum for income and assets.

2. What have been the increases in the numbers of those receiving each type of Medicaid benefit and those receiving more benefits, by type?

3. To what extent have those expansions contributed to the burgeoning costs of the program, broken down by the cost of each expansion?

See national data in GAO report, attached. (Attachment "E").

4. What other factors are fueling health care cost inflation and increasing demands on the state's Medicaid program and what have been their impacts on access to care and the quality of care?

Increasing hospital and nursing home rates, and probably pharmacy and diagnostic items appear to have the biggest impact on health care cost inflation.

5. What initiatives have been undertaken by state and local officials to continue to offer health care services with dwindling federal and state dollars?

Wayne County has incurred costs of $4 million/month since October 1 when state stopped making payments of County Care dollars.

6. What alternatives exist to provide health care services and other services with public health ramifications, i.e.efforts to provide food, drug abuse education, and counseling?

Port Huron--free "People's Clinic"

Lansing -- free "Friendship Clinic"

Detroit -- free Holy Trinity Clinic

Providers at these clinics seek specialty care from area hospitals, universities, apparently with success. Attendance at these clinics limited by geography and limited hours.

7. How much have Medicaid funding levels been reduced as a result of the state's budget deficit?

a. $11 million pulled out of Medicaid which paid for Medicaid benefits for seniors/disabled with incomes within 90% poverty level.

b. See Exhibit "B" for the exact amount of Medicaid reductions from FY 90-91 to FY 91-92. Overall--$253 million in savings created. But some of the larger savings items are things which Engler is doing little or nothing to foster--eg $46 million by developing a nursing home estate recovery program and making adult children responsible for their parents. Also, $48.5 million savings was expected from reducing rates of County Medical Facilities, but they haven't been reduced.

c. Actual "cuts":

1991 - OBRA $11 million

Chiropractic Services

Some physical therapy

Virtually all residential treatment for substance abuse

1992 - All of '91 cuts plus:

Podiatry ($1.8 million)

Dental ($18 million)

Medical transportation--limited to $.21/mile or $3 for a round trip (whichever is greater), which client can only get by applying for reimbursement. This virtually eliminates cabs. Vans for persons with special needs cut to $21/trip.

Because DSS has not reduced all of the items listed in the budget, there probably will be a deficit in the Medicaid account.

8. How many people (1) no longer receive Medicaid benefits? (2) receive fewer benefits?

Persons cuts off AFDC as a result of ratable reduction lost Medicaid figures cannot be determined. However, of interest, medically needy families (spend-down families) increased from 18,000 in January 1991 to 24,000 in September, 1991. This could represent a shift from AFDC to the medically needy program, or it could simply mean that more families had incomes low enough to qualify for medicaid between January and September. Also, of interest, in January 1991 there were 17,470 cases open for pregnant women, and in September, 1991 the number had risen to 27,509. This may suggest a number of people losing AFDC due to the cuts, and those who were pregnant would then be transferred to the Mich-Care (Pregnant women) category.

Elderly and disabled persons with incomes between $360 and 485 (approximate, depending on county of residence) lost Medicaid.

Persons who lost Medicaid due to OBRA cuts--about 16-17,000.

(2) Receive fewer benefits?

All adults have lost dental, chiropractic, podiatry,and transportation. For the most part, children's benefits have remained intact, except that DSS has cancelled its outreach contracts in EPSDT, which may well mean that children are utilizing services at a lower rate.

We would be remiss to overlook the closure of state mental health facilities already underway . The dumping of individuals suffering from serious mental illnesses into the streets to fend for themselves is among the most cynical and harmful policies being carried out in this State.

WHAT ABOUT THE SO-CALLED EMPLOYABLE?

The experience of the former General Assistance recipients in the State of Pennsylvania in their attempt to find employment provides some clue as to the current situation and likely developments in Michigan for the so-called "employables" who are no longer receiving any state assistance.

In Pennsylvania, where the reductions were not as drastic as in Michigan, the data showed that very few former recipients found employment in the year following the cuts:

> In the year after aid terminated 63.5% of the "employables" were not able to obtain any employment! Since 23.9% had been employed while they were receiving General Assistance, it appears that only about 12.6% of the caseload that had not been employed while receiving General Assistance worked at some time in the year following termination of General Assistance. Moreover, by looking at information in state employment records, the agency reports, much later in its report, that 64% of those terminated as "employable" were not able to obtain any "covered employment" (i.e., covered by Unemployment Compensation and therefore a matter of record with the State) in five quarters following termination. Only 2.7% obtained a job that lasted more than a year, and another 3.9% obtained a job that lasted more than 9 months.
>
> * * * *
>
> Thus, the increase in any employment, and particularly the increase in employment of any duration, was slight. Nonetheless, as the State notes, there was a significant increase in the number

> of employers contacted by former General Assistance recipients seeking employment increased from 4.5% while the recipients were still receiving benefits to 5.1% after termination. As one advocacy organization notes, this increase in .6% contacts per person per week, if multiplied by the 68,000 persons the State considered transitionally needy by the 26 weeks in the survey period, there would have been one million additional contact made during this period -- an astonishing number when compared to the very few jobs obtained.

Impact of Termination of Benefits for "Employables" in Michigan, Massachusetts, and Pennsylvania, Center on Social Welfare Policy and Law, 1992.

The situation in Michigan can only be worse than that of Pennsylvania, with double digit unemployment confounding the prospects of employment for thousands. The choice made by Michigan to drastically reduce human services in a recessionary economy is unwise and unsupportable.

SOLUTIONS AND RECOMMENDATIONS

On February 27, 1992, Michigan Legal Services filed suit on behalf of several plaintiff classes, including plaintiffs representing SDA, ENP, and Indigent Medical Care classes.

Plaintiffs are challenging the unlawful policies and practices in these programs, which are discussed above in some detail. Faircloth, et al. v Miller, et al., Ingham County Circuit Court, Case No. __________.

It is apparent from our experience that litigation and advocacy do not begin to address the enormous misery and crises heaped upon Michigan's poor, ill, elderly and young. Moreover, private agencies and charities cannot possibly fill the gap left by the cuts.

Soup kitchens report that they are serving more meals, and serving them earlier in the month. Operators believe it likely that clients need more food aid because they have had to sell food stamps to pay rent, have had to move from housing with cooking facilities to housing without cooking facilities, or become homeless.

The Department paid rent directly for GA recipients. When landlords received notice from DSS that no further rent payments would be made, massive eviction ensued. social welfare organizations report there has been a dramatic increase in illegal evictions. These organizations cannot provide assistance, however, because they are already overwhelmed by crises and cannot handle more persons, particularly when their own public and private funding have declined.

The attached pages from a lengthy study of emergency providers conducted before the most drastic reductions reveal that the emergency in Michigan is not and cannot be met by private agencies. More Water In The Soup, supra.

The federal government must take a look at possible measures to provide short-term emergency relief to this State and long-term solutions must be found which include assistance programs which provide benefits to the elderly and disabled not eligible for traditional federal programs and for single adults in transition, especially in times of high unemployment.

Further, the federal government can and should require states which like Michigan, receive huge amounts of federal match funds for the Medicaid program, to provide other assistance and emergency benefits to the poor. The crisis in Michigan exemplifies the absurdity of a large medicaid program which cannot meet the needs of the poor, due to deprivation of other essential services.

Strict enforcement of the MCCA would go a long distance in resolving the dilemma.

We appreciate the opportunity to submit this written statement and to testify before the Sub-committee on issues of enormous importance to the most disadvantaged citizens in Michigan.

8A DETROIT FREE PRESS/FRIDAY, FEBRUARY 7 1992

IN OUR OPINION

SAFETY NET

Gaping holes remain despite Engler's claims

The plight of a 58-year-old Oakland County woman who was rejected for Michigan's new disability assistance shows that deserving people are plunging through the safety net Gov. John Engler Wednesday called one of the nation's strongest.

The divorced onetime nursing assistant, who has a strained back, high blood pressure and arthritis, got general assistance (GA) until that was abolished Oct. 1. Soon after, she got her doctor to fill out a form for the new disability assistance. But without laying eyes on her, the bureaucracy turned her down at the end of November. At a review two weeks later, a medical social worker said her blood pressure wasn't that high. She had a stroke Jan. 25.

Now out of the hospital, she needs physical therapy but has neither insurance nor income. The state still hasn't classified her as disabled.

Making due provision for how state policies work in the world is a key challenge for Gov. Engler and the Legislature as they work out a budget for the Oct. 1 fiscal year.

Wednesday night, Gov. Engler outlined his $21 billion-plus proposal in terms too broad to see what it really means that he wants to hold the line on taxes, maintain his commitment to education funding, and assure current levels of social service payments to families, children, the aged and the disabled. Details of the budget proposal were expected today.

Mr. Engler advanced good ideas on extended day kindergarten for at-risk children and tutoring "our youngest students" in basic skills, for example, but did not say how much of the need will be met. Nor did he evince the level of commitment to school finance equity vital to the outcome.

As for his "safety net," the state still has not even notified people who used to get GA that the new disability program exists. As a result, few of the increased number of beggars in wheelchairs or on crutches in downtown Detroit seem to have heard of it. And the case of the Oakland woman shows how a decision on who gets the new state disability assistance, about $244 a month in metro Detroit, may disregard who can really get a job or even work.

DSS Director Gerald Miller says that the definition of disability is under review and may be adjusted. The problems, he says, are essentially startup ones. The assignment of only 12 medical social workers across the state to deciding the 18,000 to 20,000 pending applications for SDA suggests those "startup" problems may not get worked out soon.

By contrast, Kathleen Gmeiner, an attorney for Michigan Legal Services here, notes that the Social Security Administration processes disability applications by assigning values to a person's age, work experience, training and education, as well as to the medical or psychiatric view of the work the person can do. She argues Michigan ought to use more generous standards because people like the Oakland woman have almost nowhere else to turn.

The governor's promised compassion doesn't mean anything without effective policies. So far, the "safety net" seems designed to save him and his social programs from the reputation of heartlessness, but their pulse seems mighty low.

Issue Analysis

MORE WATER IN THE SOUP

A Status Report of Private Emergency Services Providers
in
Michigan

June 1991

Michigan League for Human Services
300 North Washington Square • Suite 401, Lansing, Michigan 48933 • (517) 487-5436

MORE WATER IN THE SOUP

A Status Report of Private Emergency Services Providers in Michigan

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About the Michigan League for Human Services

The League, organized in 1912, is a statewide organization working to improve human services in Michigan and to enhance the functioning of the state's nonprofit charitable organizations. It is supported by local United Ways through the United Way of Michigan, membership dues, grants and contributions.

MORE WATER IN THE SOUP

A Status Report of Private Emergency Services Providers in Michigan

A phenomenon probably not experienced in Michigan in the last fifty years is gripping the state's cities, towns and countryside. Breadlines are everywhere. Tens of thousands of people--invisible to all but those filling the soup bowl or handing out the used top coat--are lined up each week at church doors, community centers, and shelters to get their most basic of needs met. The following findings attempt to quantify and to describe what is happening; no attempt is made here to capture the human suffering and humiliation felt by the people in those lines--the parent who cannot meet the needs of a child, the worker who cannot find a job, the family evicted because the rent money was used to fix an old car, the wage earner's only transportation to an essential, if meager, paycheck. Human tragedies such as these do not appear in statistical analyses--they are, nonetheless, the heart of the matter.

SUMMARY OF FINDINGS

◆ The Respondent Providers

Experienced in service provision, over half of the providers have been around for more than fifteen years and provide multiple services, having grown with the expanding needs of their communities. In the respondent group, there is a large dependence on private funding sources, particularly for the one-third of the providers who are directly affiliated with a local congregation or a larger religious organization. The majority also depend on the federal government for a portion of their funding, with providers of emergency shelter particularly dependent on this source. The Red Cross has apparently evolved into more than a provider of traditional disaster relief; chapters have become ongoing providers of routine emergency services as well. For large numbers of other respondents, including the Salvation Army, emergency service provision has also evolved into ongoing basic need supplementation for their clients rather than periodic assistance to help handle a nonrecurring emergency need. Over half of the respondents reported having no larger affiliation, suggesting a truly private provision of services.

◆ The Service Population

Clients of the respondent providers are diverse in age, with nearly a quarter under the age of twenty. They also appear to be in compromised health: only a third are distinguished by providers to be in good health, with a sixth reported as having a disability. Almost 30 percent are employed and an estimated majority receive some type of help from government-sponsored assistance programs, suggesting serious problems in the adequacy of the clients' income, whether drawn from the labor force or the public assistance system.

◆ The Scope of the Need

Over 97,600 people, including 22,500 persons under 20 years old, are served in an average week by the survey respondents, who represent an estimated 18 percent of all private emergency service providers in Michigan. (See endnote for methodology.) Using this premise, it is entirely possible that 542,000 people request some type of assistance from private emergency service providers in Michigan each week, including nearly 125,000 children. Even assuming a degree of duplication--that some individuals or families may receive several services in a single week, and the caseloads reported by the

BACKGROUND

Involvement by the private sector in meeting emergency needs reflects a long-standing tradition in the United States. Prior to the "Great Depression" of the 1930s and the passage of the Social Security Act--a measure that addressed unemployment compensation, old age assistance, aid to dependent children, maternal and child health, child welfare services, crippled childrens services, and federal appropriations for public health--private service providers were the major source of assistance for those whose basic human needs were not met through their labor or family arrangements.

Religious organizations played a major role--as they do today--in the private response to human need. Nonprofit social service agencies as well have played a historic role in responding to basic needs, causing Michael O'Neill to observe in *The Third America* that "If opera companies and Ivy League universities represent the establishment side of the nonprofit sector, social agencies represent its. . . sometimes heroic, often heartrending side."

But it wasn't until the early 1980s, when the nation was buffeted by a major economic recession and the private sector was being asked by the federal administration to take up the slack caused by a 25 percent reduction in key health and social welfare programs, that researchers took a serious look at private nonprofit assistance programs. They discovered that religious congregations remained a vital force in the provision of human services, through both their direct service provision and their socializing of individuals to the importance of charitable giving and voluntarism. In the early to mid-eighties, an Urban Institute study confirmed that almost half of religious congregations nationwide were providing emergency food, and one in three was providing cash assistance. Seventy percent had increased their subsistence programs in response to increased demand.

In some ways hampering the congregations' ability to broadly impact on the problems, researchers discovered that expenditures on subsistence service activities delivered locally are more substantial among wealthier congregations than poor ones, where the need is greatest. It was discovered that black churches, which serve constituencies that often contain disproportionately large numbers of poor people, tend to respond more readily to appeals to help individuals in immediate need than to other good causes; in response to the climate of the early eighties, many of them instituted broadened social services programs which remain today.

Michigan-specific data on private social service delivery is woefully lacking, although the League did undertake a study in the early 1980s which shed some light on the status and services of the state's voluntary service sector. A significant share of agencies--one in four--were providing emergency services in the areas of food, shelter and utilities. However, an assessment of the scope of emergency services provision was not a specific objective of the study. Religious congregations were not included among the surveyed service providers, limiting the usefulness of the study in measuring the scope or focus of emergency services being provided in Michigan during that period.

Between 1989 and 1991, local hearings on emerging needs were held quarterly by the League's Public Affairs Committee in various geographic areas in Michigan, creating the only window available on the activities of private service providers prior to the study. To the degree that this local testimony validates or contradicts the study's findings, it is incorporated in the following narrative.

240. people each week: forty-three percent served over 100, and about 17 percent served over 500. (See Figure 1.) In the aggregate, the respondent providers--which represent an estimated 18 percent of all providers in the state--assisted 97,600 persons in an average week. It should be noted that the count of people is not necessarily unduplicated--the same individual may have received several services from an agency during a single week. The totals may more accurately reflect the number of requests for assistance to which an agency responded in an average week.

"Our program of occasional help in the neighborhoods has long since expanded."

Macomb County

Most providers (over 75%) do not limit their services on the basis of gender, age, or family structure--they attempt to serve any persons needing assistance. The remainder provide services to special, categorical populations such as abused women and/or children.

Types of Services Provided

The providers offer a broad range of services, emergency and otherwise: roughly 70 percent of the respondents reported providing at least four different types of services. Food boxes and clothing are the most commonly offered service, followed by transportation assistance. (See Table 1.) In rural counties, providers are most likely to provide heating or other utility assistance due in part to different billing and use patterns in those areas.

Table 1

Type of Service	% of Respondents Providing the Service
Food Boxes	58.6
Clothing	58.6
Transportation Assistance	45.4
Shelter	43.6
Heating/Utility Assistance	38.3
Prepared Meals	34.4
Education/Job Training	23.3
Medical Care	23.3
Cash Assistance	20.7
Mental Health Services	11.0
Dental Care	7.9
Other	23.8

"We are considering shifting to two kinds of food boxes--one for persons who can store and prepare food, and one for the homeless. . . canned goods are too heavy for people who carry around everthing they own all day."

Ingham County

A large number--three in four of the respondents--also report that they provide information and referral services. Some other less common services include: the provision of furniture, housing assistance, services for senior citizens, children's services, counseling, advocacy, personal need items (e.g., toiletries), and legal assistance. Providers appear to be trying to tailor their services to meet the changing needs of their clients. For example, as providers are becoming more aware of the growing problem of homelessness, some are initiating plans to move toward offering more prepared meals and fewer food boxes. Others are experimenting with the provision of two types of food boxes: one to serve homeless clients and another for those with access to utensils for food preparation. The boxes for the homeless are generally more expensive to prepare as they must include things like paper products and can openers. Personal mobility is also being addressed as an

Seven in ten respondents were forced at some point to turn people away. Those reporting that they are unable to serve all those in need indicate that they turn away between 1 and 500 per month, dependent upon the size of the agency and the scope of its services. Not all denials are due to depleted resources–some of the persons turned away don't meet eligibility requirements set by the agency, either because they don't belong to the specialized population served by the agency, or don't live in the geographic area served. Others have no form of identification, or can't meet the low-income guidelines set by the respondent. A certain portion are turned away because they request a service that is not available. One in three have previously received assistance within an agency's allowable time frame. Finally, over 40 percent are turned away because the agency or organization has reached its capacity and can offer no more services. It should be noted that many agencies with current income-related eligibility guidelines are lessening restrictions as it gets more and more difficult to provide for an individual or family at or near the designated poverty level.

"Maxed out"

Marquette County

Waiting Lists

A quarter of the respondent providers currently have waiting lists in place. An average of thirty persons are on a single agency waiting list at any point in time, and the average wait is roughly seven weeks. Waiting lists for emergency services providers appear to be a relatively new phenomenon, and are more typically found where requests have been made for furniture, housing assistance, weatherization and mental health or substance abuse counseling. For more urgent, life-threatening emergency needs, agencies tend to refer persons to other providers rather than place them on a waiting list.

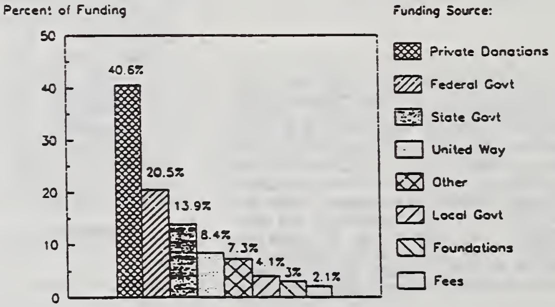
Agency Funding

The "typical" respondent provider receives funding from a variety of sources. (See Figure 3.) Eight of ten respondents utilize private donations, but less than 20 percent are solely dependent on them. The federal government is another major source of funding for the respondents. Sixty percent receive

"Funding is declining as more clients are seeking help."

Kalkaska County

Figure 3. Funding Sources of Average Provider

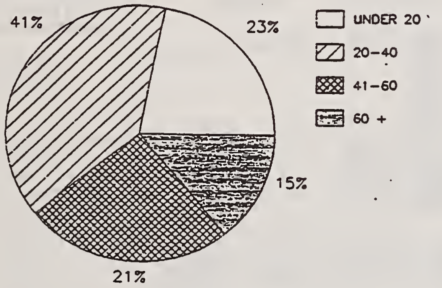


PROFILE OF CLIENT POPULATION

Demographics of Persons Served*

For the average respondent provider, almost one-quarter of the persons served are under the age of 20, with one in two of the agencies reporting that at least half of their clientele is 20 years of age or younger. (See Figure 5.) Using an estimate of the share of Michigan providers reached by the survey, this finding suggests that approximately 125,000 children have a basic emergency need each week in Michigan for which they, or their parents for them, are requesting assistance from private emergency services providers. This projection of children's needs is modest given that in many agencies, persons requesting services on behalf of their children are counted as an adult served; the children are not included in the count.

Figure 5. Age Distribution of Clients



"Folks are living day to day in shock . . . and so are we!"

Berrien County

In the average respondent agency, 15 percent of the service population were observed by providers as being disabled, with an additional 56 percent observed as being only moderately healthy. (See Figure 6.) This would

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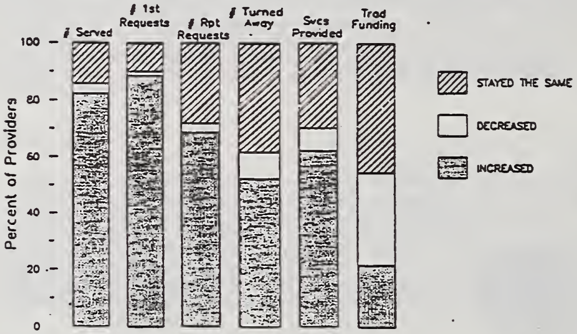
* A significant portion of the respondent providers did not answer the questions regarding service population characteristics. Many of them reported that such information is not relevant to their provision of services and, therefore, they do not collect it.

LOCAL VIEW OF TRENDS AND FUTURE CAPACITY

Pressures on the System

Trends over the last three years indicate that pressure on the private emergency service sector is growing. Eight in ten providers report an increase in the total number of persons served and 90 percent see an increase in requests for assistance from people who have not previously needed help. (See Figure 8.) Over two-thirds report an increase in requests for repeat assistance as well, and half have been forced to turn away a greater number of those in need. They appear more pessimistic, if anything, than the providers in an agency survey the League undertook in 1982-83, when slightly under half of the agencies reported that they could not keep up with the increased demand. Fully 94 percent of agencies providing emergency services felt increased demand during the economic downturn of the early 1980s.

Figure 8. Trends In Service Needs and Funding Support, 1988-1991



During the current period, over 60 percent of the respondents have expanded the number and types of services they provide, with a third citing increased community demand as the reason. Other providers, however, are being forced into financial deficit in order to continue to provide the current level of services.

Seventy percent of the respondents have seen a change in the characteristics of persons requesting assistance in the last few years. An overwhelming two-thirds report serving more persons with problems connected to their work force participation, either under-employment (working poor) or unemployment. Three in ten cite a rise in families seeking assistance. Other frequently mentioned changes include: more young adults (14.5%), more people receiving public assistance (10.2%), and an increase in homelessness (8.5%). Relating to the homelessness question, a lack of affordable housing around the state--particularly in rural areas--was frequently mentioned by respondents as a major cause of hardship in their area.

"Unless increased financial support is forthcoming, I don't believe existing resources can accommodate additional demand."

Ottawa County

"HELP!"

Wayne County

services, only a quarter of them predict that the community will be able to do so. (See Figure 10.) Even more pessimistic, only 8 percent of those in rural areas see any possibilities of added community support. In certain communities, organizations are trying to coordinate efforts in an attempt to meet expected additional demands. These groups of providers are making it quite clear, however, that this increased effort can only be maintained for a short period of time, until more long-range solutions are developed.

Of those that believe that the community is not able to expand support, one-half point to a general lack of community resources, resulting in reduced private contributions.

Another 17 percent believe that the demand for services will outstrip the ability of the community to respond, while a small percentage feel that their communities are just not interested in expanding to meet the need. Nearly one in ten said expansion for all emergency service providers will depend on new funding sources, resulting in fierce competition for any available resources in the private sector.

"With the demand for services increasing dramatically, it is impossible to expand programs without expanding financial support."

Ingham County

CONCLUSION

Environmental Factors

The League's survey of private emergency services providers in Michigan clearly demonstrates that there is a high level of need for emergency services and that the private sector is currently handling a large number of requests for such assistance. The survey also demonstrates that a growth in the need for services is coupled with a decline in the resources available to respond to that need. It is clear that most emergency services providers are pessimistic about their ability in the future to marshall the resources necessary to meet additional demands for help with such basic needs as food and shelter. The resulting pressures on private emergency services providers are obvious. The causes of these pressures are somewhat more complex and include the following significant environmental factors:

- **Changes in Michigan's economy have made it more difficult for families to support their children.** Higher-paying jobs in manufacturing and the auto industry have disappeared, and been replaced by lower paying service jobs. The earnings of substantial numbers of workers have not kept pace with in-flation. Many families cannot meet their basic needs even though one or more members are employed, in part due to low wages, spells of unemployment, or involuntary part-time work. Nationally, between 1973 and 1986, the real median income of young men fell 25 percent, with high school dropouts experiencing a 42 percent decline and black men a 44 percent loss. The survey confirmed that a large percentage of persons seeking emergency assistance are connected to the work force.

- **Poverty, and particularly child poverty, increased during the 1980s.** The child poverty rate increased nationally by 21 percent in the last decade and by 53 percent in Michigan, primarily in response to economic and labor market changes affecting families. This rate is further exacerbated by changes in family structure. Marriage rates are declining, and children are increasingly being raised in single-parent families, where they are at much greater risk of poverty. Nationally,

"Resources shrinking--community concern contracting."

Washtenaw County

- The Emergency Needs Program (ENP) was reduced by (1) prohibiting payments for water and sewerage service; (2) reducing or eliminating allowances for major appliances; (3) reducing payments for burials, and (4) reducing supplemental shelter allowances for single individuals.
- Special emergency needs contracts were reduced.

The Children's Defense Fund (Washington, D.C.) estimates that the declining effectiveness of government programs in pulling families out of poverty accounted for 42 percent of the increase in poverty rates for families with children between 1979 and 1987. Our survey confirmed that--even prior to the 17 percent reduction in AFDC and GA grants in March of this year--certain agencies were experiencing a rise in the number of public assistance recipients seeking help from private emergency providers. Between 1980 and 1991, the purchasing power of the maximum AFDC and GA grant in Michigan fell by approximately 28 percent. As a result, prior to the March grant reduction, less than one-third of AFDC recipients and approximately one-quarter of GA recipients received enough in their shelter allowance to cover their shelter expenses. It is anticipated that the grant reductions will jeopardize the housing arrangements of many public assistance recipients, and that homelessness and requests for emergency shelter will increase.

The Governor has recommended that the current General Assistance and Job Start programs be eliminated, ending all income support for over 98,000 persons statewide. If this "last resort" assistance program for persons ineligible for other assistance is eliminated, private emergency services providers could experience a substantial surge in requests.

"When it comes down to what is really needed, this may be beyond what private groups can do."

Gr. Traverse County

Finally, the Governor has also recommended that all special energy assistance programs be eliminated in fiscal year 1992, and that the Emergency Needs Program be modified. Funds currently spent on emergency needs would be combined into an Emergency and Medical Needs Block Grant to the counties, with total funding reduced by approximately 70 percent. The funds for reimbursement to private agencies providing emergency services would be substantially diminished. Control over the resources would be shifted to local governments, which may be sorely tested by the need to both create an administrative structure for eligibility determinations and manage extremely limited resources in the face of growing demand.

Solutions Not Readily Apparent Nor Easy

Given the above environmental factors and what appears to be a level of unmet basic need which is broad and deep and affecting large numbers of citizens in every corner of the state, an adequate response on the part of public and private decision makers will be neither easy to fashion nor quick to implement. Taking the first steps toward a solution, however, is critical to the state's economic survival and competitive standing in a rapidly changing world.

Appendix A

URBAN/RURAL DIFFERENCES

For purposes of this comparison, all providers in the targeted counties with a 1990 Census population of under 100,000 are considered rural; the remainder are considered urban.

1. **Caseload Size:** For obvious reasons, the majority of respondent rural providers serve smaller numbers of people, although the average number served per week is similar (243 urban vs. 214 rural).

Number Served Weekly	% of Respondents	
	Urban	Rural
<50	37.6	58.1

2. **Service Provision:** The most frequently reported rural service is heating/utility assistance, while in urban counties it is food boxes.

Type of Service	% of Respondents Providing the Service	
	Urban	Rural
Food Boxes	60.5	46.9
Shelter	41.5	56.3
Prepared Meals	35.4	28.1
Heating/Utility Assistance	34.9	59.4
Substance Abuse Services	19.5	3.1
Child Care	12.8	25.0
Mental Health Services	12.3	3.1

3. **Client Characteristics:** More rural clients are employed, and enjoy better health.

Relationship to Laborforce	% of Clients	
	Urban	Rural
Employed	27.1	40.4
Unemployed	72.9	59.6
Health Status		
In Good Health	29.9	46.3
Compromised Health	54.7	43.2
Disabled	15.4	10.5

APPENDIX B

COUNTIES SURVEYED

Targeted Counties

Alpena
Bay
Berrien
Chippewa
Genesee
Grand Traverse
Ingham
Isabella
Jackson
Kalamazoo
Kent
Lake
Lenawee
Macomb
Marquette
Muskegon
Oakland
Saginaw
St. Clair
Wayne

Additional Responses

Clare
Clinton
Gratiot
Kalkaska
Mason
Montcalm
Washtenaw
Wexford

7/11/91/wp50/a:stat.til/pk/ml

Predictions

An overwhelming 93 percent of the respondents predict that they will be confronted with added requests for assistance in the future, with nearly 60 percent needing to limit services even further and facing more persons they will be unable to serve. Nearly one-quarter also added that the amount of services available will decline with increasing needs, and some predict they will be forced to redefine their eligibility criteria. One of the agencies resurveyed had closed.

Despite the fact that over half of the respondent providers reported that they would be able to handle present and future changes, they had reservations about this ability. Of the half that said yes, nearly 30 percent qualified this answer by conditioning more assistance on increased donations or other funding increases; another 20 percent qualified their answer by adding they could only cope with great difficulty or by limiting or ending some services temporarily, if not permanently. A few providers answered that their ability to respond would be dependent upon whether other providers could pick up some of their slack.

Of all the respondents, nearly a third reported that the time was fast approaching when they would be forced to redefine the functions of their organization; they would have to prioritize and make major programmatic changes, possibly no longer providing more costly services such as shelter or transportation, or limiting food assistance to fewer times per week, or per month.

addend.pk2

Community & Economic Development Department
Housing for the Homeless Programs Unit
Residential Hotel Survey - GA Cuts
October 16, 1991

Hotel/Location	#GA Tenants	# Left Voluntarily	#Evicted	# At Risk Eviction	Other Note
American Ft. Wayne 408 Temple	20	1	-	16	
Ansonia 2447 Cass	31	3	-	28	
Billingshurst 71 W. Willis	110	50	-	60	Hotel may close.
Blackstone 4434 2nd	45	-	-	45	Hotel may close.
Devur 1129 Milwaukee	100	-	-	60	
Detroiter 2560 Woodward	220	-	-	199	Hotel may close.
Eddystone 110 Sproat	45	-	45	-	
Ft. Wayne Grand 4070 W. Fort	75	-	75	-	Hotel closed.
Huntington 109 W. Alexandrine	100	35	32	33	Hotel may close.

Hotel/Location	#GA Tenants	# Left Voluntarily	#Evicted	# At Risk Eviction	Other Note
Hollywood 466 Henry	23	-	-	23	
King's Arms 470 Myrtle	115	85	-	30	Hotel may close.
LaRose 507 E. Bethune	3	2	-	1	
Leland House 400 Dagley	2	-	-	-	Hotel offered tenants jobs to make up rent.
Lillibridge 11105 E. Jefferson	68	-	-	68	Hotel may close.
Madison/Lenox 246 Madison	4	-	-	4	No problem yet.
Milner 1530 Centre	10	-	-	10	
Milner Arms 40 Davenport	12	7	-	5	
Roosevelt 2550 14th	60	15	15	30	Hotel may close.
Normandie 11626 Woodward	0	-	-	0	All tenants employed.
Seville 3160 2nd	75	-	75	-	Hotel closed.
Park Avenue 2305 Park	3	-	-	3	
Willard 448 Henry	180	25	60	95	Hotel may close.
Yorba 4020 W. Lafayette	160	65	75	20	Hotel may close.
Totals:	1,461	288	377	730	

CAG
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COTS MONTHLY STATISTICS

MONTH OF August 1991

repared by: Cherry Stallworth

		ACTUAL		%	
		MALE	FEMALE	MALE	FEMALE
NEW INTAKES	ADULTS	107	91	40	34
	CHILDREN	70		26	
TOTAL NEW INTAKE		268 (*ADI 8.6)			
PRIOR MONTH CARRYOVER	ADULTS	57	50	37	32
	CHILDREN	48		31	
TOTAL CARRYOVERS		155			
TOTAL SERVICED/MONTH		423			
UNABLE TO SERVICE	ADULTS	62	175	15	41
	CHILDREN	184		43	
TOTAL UNABLE TO SERVICE		423 **(13.6 ADTA)			
AVERAGE LENGTH OF STAY (SINGLE PERSONS)		4,776/241		19.8 days	
BED CAPICITY UTILIZED		4,712/4,340		108%	
GENERAL STATISTICS					
RELOCATIONS		57		26	
TERMINATIONS		160		74	
NEW INTAKES					
RE-ADMISSIONS	ADULTS	38	29	46	35
	CHILDREN	15		18	
TOTAL RE-ADMITS		82			
BLACK		102	87	52	44
WHITE		5	2	2	1
NATIVE AMERICAN		0	0	0	0
HISPANIC		0	2	0	1
OTHER		0	0	0	0

* Average Daily Intakes ** Average Daily Turn-Aways

TS MONTHLY STATISTICS August 1 thru August 31 1991

REASON FOR SEEEKING SHELTER	ACTUAL	%
viction/Landlord	57	28.7
ction/Friend or Family	60	30.0
victed AFC/Home for Aged	1	0.5
Residence/No Income	33	16.6
bery	4	2.0
rison Release	1	0.5
ansient (Out of City/State)	3	1.5
ospital/Treatment Release	6	3.0
Outs	7	3.5
ilities/Shut Off	3	1.5
buse		0
safe Living Conditions	18	9.0
ther	5	2.5
TAL INTAKE	198	99.3
ATED:		
tal # Of Substance Abuse	71	36
tal # Of Mental Health Related	13	7

-vised 12/13/90

09/16/91
completed

COTS MONTHLY STATISTICS
(NEW INTAKES ONLY)

TH OF ____August____ 1991

repared by: Cherry Stallworth

	ACTUAL		%	
ULTS	MALE	FEMALE	MALE	FEMALE
	107	91	54	46
-30	47	43	23.7	21.7
1-50	56	45	28.2	22.7
over	4	3	2	1.5
HILDREN				
-2	30		43	
	16		23	
	23		33	
3-17	1		1	
TOTAL CHILDREN	70		100%	
ERANS				
AL FAMILY UNITS SERVICED	40(N) + 24(C)=64 serv.		20 N	
ALE HEADS OF HOUSEHOLD	40 N		100	
ALE HEADS OF HOUSEHOLD	0			
OTH PARENTS PRESENT	0		0	
. NO. CHILDREN PER. FAMILY (N)	1.3			
. LENGTH OF STAY FAMILIES (*IC)	1266/64		20 days	
DULT GRADE LEVELS				
	4		2	
	1		.5	
th	5		2.5	
th	13		6.5	
th	30		15.1	
th	50		25.2	
iploma/GED	95		47.9	
2 yrs. COllege				
yrs College				
nanswered				

= carryovers   N = new intakes   *IC = includes carryovers

MED-LAW ASSOCIATES, P.C.

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October 11, 1991

Representative David C. Hollister
State of Michigan
House of Representatives
Suite 560 Roosevelt Building
Lansing, Michigan

Dear Representative Hollister:

We are writing you because you seem to be one of the few people who understand the enormity of the mistake Michigan is committing with respect to the General Assistance recipients who have been left with no source of income or support. We have some observations of this situation which we have not heard others mention and would like to share them with you for whatever value they may be in your efforts to restore financial and medical assistance to people who do not have the ability to care for themselves.

We are lawyers and social workers who have worked a total of 30 years within the Department of Social Services and with General Assistance recipients. A significant portion of our work now consists of representing clients in their efforts to qualify for Medicaid. This service is sponsored by hospitals which have cared for indigent patients without compensation.

Over the past 2-1/2 years our organization has worked with well over a thousand clients. Approximately two-thirds were so-called able bodied GA recipients. To date more than fifty percent of these people have qualified for Medicaid for the disabled. Approximately one-third qualified based on a mental impairment.

These findings comport with the experiences of one of the undersigned, while she was a Client Advocate within the Department of Social Services. In that job, she conducted a pilot study at the Ingham County Department of Social Services. In that pilot, so called "able bodied" GA recipients (non-Medicaid) were selected for evaluation after they tried unsuccessfully to qualify for Supplemental Security Income (SSI) through the Social Security Administration. Once these clients' impairments were properly documented, approximately eighty percent were found to be disabled.

This pilot (and a similar study performed in Kent County by Gary van't Hul, an administrator there) led to a statewide "GA Initiative", as it was called, to identify disabled people among the GA population. These people were to be identified through a survey form completed by each worker at time of case opening or case review. In the few counties where the initiative was taken seriously, the results were dramatic. Many disabled people were identified, qualified for Medicaid and then for SSI. The results were impossible to refute; there were large numbers of disabled people on General Assistance.

In our current work, we have had an opportunity to take a very close look at large numbers of GA recipients and at the DSS process. What we have found has led to the inescapable conclusion that the course now being taken with these people is wrong and is bound for disaster. This conclusion is based on our observations that large numbers of them are not only incapable of self-support, but are incapable of demonstrating their eligibility for benefits.

What we see is that many people have been characterized as able bodied by default. This has occurred for several reasons. First, these people have not had the wherewithal to leap through the challenging hoops which DSS sets up for anyone who tries to qualify for Medicaid. Second, they may not have even attempted to obtain Medicaid because they didn't know they were disabled. This is often the case with people who are mentally impaired. It is our impression that the most severely mentally impaired can seldom negotiate the system well enough to qualify for Medicaid.

The barriers to Medicaid are significant. A few of them are as follows:

1. We have frequently been told by clients that a DSS worker told them they were not eligible for Medicaid and thus discouraged filing.

2. The application form is 28 pages. It is daunting to someone with minimal education. It is sometimes confusing even to us -- and one of us helped design it.

3. The verification requirements are often insurmountable. We have attached several actual verification check lists which were sent to Medicaid applicants. Claimants are given 10 days to procure all the items, many of which are unavailable to them. We have seen many workers check off every box and then deny people for not returning the verifications requested, even those which were not appropriate. It is an easy way for an overburdened worker to reduce the workload.

Verifying the presence of a disabling condition is a special problem. The DSS Manual directs that, when needed, the worker is to assist client with scheduling a medical examination appointment, paying for medical evidence and/or medical transportation. (PAM Item 815, page 5), but in reality the workers do not have time to do this. The clients are merely given the forms to take to the doctor. These people don't have doctors who will fill out the required forms given to the client by DSS. Even when the client has a doctor and gives the doctor the forms to complete, they are seldom returned to DSS within the 10 day limit. This factor, which was completely beyond the client's control, results in the Medicaid application being denied for failure to supply information even though it was not possible for the client to personally provide it.

As you can see, the DSS system is extremely complex. Its complexities overwhelm many disabled clients so that they never become entitled to programs which would identify them as people who should be placed in a protected class.

We are well aware that changes in the General Assistance program were needed. But these changes should have been made with consideration of the condition of the people being affected.

The new SDA program which was contrived to fill the gap left when GA ended, will not help the people we have described. To qualify medically for SDA, one must be incapable of performing "any remunerative work". I have been personally told by people within the Medicaid program that the word from Mr. Miller is that people who are capable of even $1.00 an hour babysitting will be ineligible. This standard is far more severe than the

Medicaid standard where the client's ability to perform "substantial gainful activity" is the criterion.

I am attaching sketches of several "able bodied" former GA recipients. These people are only pending Medicaid because we filed the application and provided the necessary information. Most had never applied for Medicaid prior to their involvement with us. This information is provided without identifying the individuals because we did not have time to obtain releases for this purpose. If more specific information would be helpful, I am sure it could be provided.

If there is anything else we can do to support your efforts, please call.

Sincerely,

Ellen M. Hart
Ellen M. Hart
Attorney at Law

Marsha E. Wood
Marsha E. Wood
Attorney at Law

P.S. We are puzzling over a DSS Program Policy Bulletin, Number 91-8, which we received yesterday. It refers to continuing medical coverage for GA recipients, but we know from the dozens of telephone calls we have received that there is no medical coverage for these people at this time. A copy of PPB 91-8 is attached.

GA MEDICAL AND STATE MEDICAL PROGRAM COMPARISON

MEDICAL SERVICE	*GA MEDICAL **	*BASIC COVERAGE*	*LIMITED COVERAGE*
Physician (M.D./D.O.)	All services (No copayment)	Most ($2.00 copayment)	Limited ($2.00 copayment)
Pharmacy	Drug formulary ($.50 copayment)	Drug formulary ($1.00 copayment)	Drug formulary ($1.00 copayment)
Laboratory	Yes	Yes	Limited
Radiology	Yes	No 2/6 G Miller says: "yes"	No
Outpatient hospital	Yes	Most	No
Medical supplies	Yes	Most, excluding those needing PA	No
Emergency transportation	Yes	Ambulance transport to ER only	No
Nonemergency transportation	Yes	No	No
Dental	Yes **	No	No
Hearing	Yes	No	No
Vision	Yes	No	No
Family Planning	Yes	No	No
Home Health	Yes	No	No
Durable medical equipment	No	No	No
Speech, occupational therapy	No	No	No

* The GA Medical Program also describes the Wayne County CountyCare Program. In addition, CountyCare includes inpatient hospital care.

** The CountyCare Program includes a capitated dental coverage. The GA Medical Program was a fee-for-service dental coverage.

Prepared by Office of Rep. David Hollister (D) Lansing, Chair
Michigan House Social Services Appropriations Subcommittee

GA AND JOB START FACT SHEET

1/11/91

What Are General Assistance and Job Start?

- General Assistance (GA) is a cash assistance program for low-income persons with less than $250 in assets.

- GA recipients are not eligible for AFDC because they do not have children or else do not meet federal requirements for AFDC - Unemployed because of insufficient prior work experience.

- GA recipients are not eligible for Supplemental Security Income (SSI) either because they do not meet the age criteria, are not blind, or have not been determined to be disabled. Many recipients do apply for SSI disability and are eventually found to be eligible. The state is reimbursed by the Federal government for General Assistance payments made to such persons while they were awaiting SSI eligibility determination.

- The average monthly GA cash benefit in FY 1989-90 was $217 for cases without children and $458 for cases with children. GA recipients are also eligible for the General Assistance Medical and Resident County Hospitalization program. In many counties, the medical coverage does not include hospitalization.

- Persons aged 18-25 who meet General Assistance eligibility requirements in six counties (Genesee, Ingham, Kalamazoo, Muskegon, Oakland, and Wayne) are required to participate in the Job Start program, a mandatory employment and training program initiated on a pilot basis in FY 1989-90. Participants receive training allowances averaging $196 a month while participating in education and training activities, but are not eligible for General Assistance if they do not participate.

Who Are General Assistance Recipients and Where Do They Live?

Sex of Household Head	
Male	57%
Female	43%

Race of Household Head	
White	52%
Black	44%
Other	4%

Age of Household Head	
21 & Under	9%
22-40	57%
41-54	23%
55 & Over	11%

- Over 20% of General Assistance recipients are children. Figures for October, 1990 for the state and selected counties are:

	Cases	Total Recipients	Children	Adults	% Children
Statewide	98,394	152,564	32,332	120,232	(21.1)%
Wayne	48,166	62,354	8,749	53,605	(14.0)
Genesee	7,434	15,294	4,807	10,427	(31.4)
Ingham	2,255	4,611	1,475	3,146	(31.9)
Saginaw	4,051	8,287	2,618	5,669	(31.5)
Roscommon	307	491	108	383	(21.9)
Marquette	464	741	141	600	(19.0)
Berrien	1,222	2,147	588	1,559	(27.3)

- Roughly half of the General Assistance population resides in Wayne County. However, Wayne County's portion of the total state caseload has declined by 14% since 1981.

- Caseloads have increased substantially over the last year, with the greatest increases in outstate counties. Data for the counties with the largest November, 1989 and 1990 caseloads are attached.

To What Extent Are General Assistance Recipients Employable?

- In addition to physical and mental capabilities, the keys to employability are educational level and employment experience. The education and employment experience levels for General Assistance recipients is as follows:

Education		Employment Experience
Less than High School Diploma	49%	61% have no history of employment
High School Diploma	41%	66% have not worked in the last five years
Some College	10%	

- Only 15% of all General Assistance recipients meet the Armed Forces recruiting criteria.

- Another Key factor in determining eligibility is the availability of jobs in reasonable proximity to where recipients live:

  * The clear and powerful relationship between General Assistance caseloads and unemployment rates is well known. General Assistance caseloads are usually the highest in counties and cities with the highest unemployment rates. For example, there are already large numbers of applicants for each available job opening in Detroit and many other areas with large numbers of recipients.

  * To the extent that unemployment rates are high, General Assistance recipients who are successful in finding jobs may simply displace other workers with marginal skills.

- There have been several studies of General Assistance recipients in Michigan over the past several years. All have emphasized the importance of education and training in making recipients employable.

- The apparent willingness of GA recipients to participate in education and training activities has been demonstrated by Job Start. The drop-out and sanction rates have been lower than anticipated in this program, and participation rates have been higher than budgeted. Over 11,000 18-25 year olds now are receiving education and training in the Job Start counties.

GENERAL ASSISTANCE CASELOADS
NOVEMBER 1989 - NOVEMBER 1990
COUNTIES WITH GA CASELOADS ABOVE 1,000

COUNTY	NOV 89	NOV 90	% CHANGE NOV 89-NOV 90
Bay	1,692	1,652	-2.4%
Berrien	1,015	1,272	25.3%
Calhoun	1,813	1,962	8.2%
Genesee	6,960	7,577	8.9%
Ingham	2,079	2,323	11.7%
Jackson	1,137	1,272	11.9%
Kalamazoo	1,505	1,485	-1.3%
Kent	1,978	2,396	21.1%
Macomb	1,547	1,905	23.1%
Muskegon	1,466	1,468	0.1%
Oakland	2,796	3,376	20.7%
Saginaw	4,078	4,220	3.5%
St. Clair	1,297	1,465	13.0%
Washtenaw	822	1,025	24.7%
Wayne	45,442	49,022	7.9%
SUBTOTAL	75,627	82,420	9.0%
Rest of the State	17,705	19,193	8.4%
TOTAL	93,332	101,613	8.9%

DEMOGRAPHIC PROFILE
General Assistance Adult Program

Job Skills	
Low Skill	34 2%
Med Skill (Total)	61.5%
Retail	3.6%
Factory Work	4.9%
Food Service	5.5%
Clerical	9.5%
Building Service	13.6%
Child Care	1.4%
Miscellaneous	23.1%
High Skill	4 3%

Recipients Employed During Last Five Years By Job Skill Level	
Low Skill	21 8%
Med Skill	
Retail	61 1%
Factory Work	66 7%
Food Service	55 6%
Clerical	74.4%
Repair and Bldg Ser	52.2%
Child Care	42 8%
Miscellaneous	49.7%
High Skill	51.2%

Recipients Employed During Last Five Years By Age	
18 - 21	61.3%
22 - 30	55.4%
31 - 40	51.8%
41 - 54	31.4%
55 - 64	31.4%
65+	0%

Percent of Recipients Employed During Last Five Years By Education Level	
None - 5th	22.7%
6th - 8th	26.5%
9th - 11th	39.8%
12th	51.2%
Some College	73.1%

Recipients Employed During Last Five Years by Location and Race	Out-Counties	Wayne
White	61.1%	41 0%
Black	46.6%	31.3%
Other	50.0%	45.5%

Marital Status	
Divorced	24.3%
Married	10.4%
Never Married	48 8%
Separated	11.4%
Widowed	5.2%

Education Level	
None - 5th	4.4%
6th - 8th	9 8%
9th -11th	34 4%
12th	41.3%
Some College	10.4%

PLAINTIFF'S
EXHIBIT
1
10-3-9

EMPLOYMENT HISTORY

- 8.6% were employed.
- 60.8% had no history of employment. The majority indicated they have not been employed during the last five years.

BARRIERS TO SELF-SUFFICIENCY

- 20% required care for disabled adults in their household for them to work.
- 22.2% had some form of physical limitation
- 28.6% had no access to transportation. 32.7% had a private vehicle. 38.5% had access to public transportation.
- 3.8% indicated they had serious mental illnesses.
- 6.1% indicated they have received substance abuse treatment.
- 61.2% of all GA recipients had at least one of the following barriers hindering their ability to work:

  Physical limitation
  Mental health problems
  Substance abuse problems
  Low job skills
  Lack of transportation
  Criminal record
  Lack of education
  Lack of recent job market contact

United States General Accounting Office

GAO

Report to the Chairman, Committee on Finance, U.S. Senate

June 1991

MEDICAID EXPANSIONS

Coverage Improves but State Fiscal Problems Jeopardize Continued Progress

GAO/HRD-91-78

Table 2.2: Average Annual Percentage Growth Rates for Population. Medicaid Recipients. and Expenditures (1984-89)

Population/ recipients/ expenditures	Most limited quartile	Least limited quartile	National average
Total population	1.2%	1.6%	1.0%
Medicaid recipients	4.8	0.1	2.1
AFDC Medicaid recipients	4.9	−1.3	1.2
Medicaid expenditures	13.0	10.9	10.0
AFDC Medicaid expenditures	17.6	7.5	10.5

These growth rates signify that the quartile that was most in need of improvement consistently served more AFDC as well as total recipients through Medicaid in 1989 than in 1984. The opposite trend is observable in states that in 1984 generally had the most comprehensive Medicaid programs in terms of eligibility and resources expended. For this quartile. AFDC recipients declined in absolute terms as well as relative to an essentially stable total. as shown in table 2.3.

Table 2.3: AFDC Recipients as a Percentage of Total Medicaid Recipients (Fiscal Year 1984-89)

Fiscal year	Most limited quartile	Least limited quartile	National average
1984	62.5%	72.9%	71.6%
1985	62.7	72.2	71.4
1986	63.0	71.6	71.1
1987	63.0	70.3	70.4
1988	64.1	70.2	70.2
1989	65.3	70.4	70.5

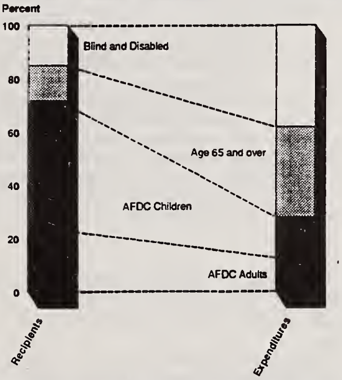
Expanded Services to Women and Children Not Primary to Rise in Medicaid Expenditures

In general. the states do not perceive expansions targeting pregnant women and children as the primary factor in rising Medicaid expenditures. The states recognize the potential benefits of such expansions. viewing prenatal and child care as a worthwhile social goal. In many instances. prenatal care services were already provided. using state and local funds. so savings resulted when the new legislation authorized a federal match. Moreover. the health care needs of these groups are relatively predictable and cost-effective. There is evidence of both short- and long-term savings in health care costs from the provision of prenatal and preventive medical benefits.

An Institute of Medicine study—Preventing Low Birthweight (Washington. D.C.. National Academy Press: 1985)—reported $3.38 savings for every $1 expended on prenatal care. Also. each dollar spent on childhood immunizations has been shown to save more than $10.

As the results of our study confirmed, relative to other groups these recipients did not cause major cost increases during the 1984-89 period. Children are the least costly of all Medicaid recipients: their per capita expenditures for medical services in fiscal year 1989 were $699. Even the larger category of AFDC recipients, while costing more per capita in 1989 than in 1984, still constitutes a relatively inexpensive group to serve. For AFDC recipients as a whole, 1989 per capita Medicaid expenditures were $867, compared with an average $2,318 overall. They consume a much smaller percentage of Medicaid expenditures than would be accounted for by their proportion of the Medicaid population (see fig. 2.1).

Figure 2.1: Distribution of Medicaid Recipients and Expenditures (Fiscal Year 1989)



Note: The category AFDC children includes individuals under age 21 who meet AFDC income and resource limits but not the AFDC definition of dependent child

Nationwide, AFDC recipients accounted for less than one-third of the growth in Medicaid expenditures between 1984 and 1989, as shown in table 2.4.[14] The elderly and disabled population generally is more expensive to serve and has grown at a faster rate. Between 1984 and 1989. this segment grew from 24 to 27 percent of Medicaid recipients and in 1989 accounted for 73 percent of the expenditures.

Table 2.4: Expenditure Growth Attributable to AFDC Recipients
(Fiscal Year 1984-89)

Fiscal year	AFDC increase as percent of total increase in Medicaid provider payments
1984-85	23.8%
1985-86	28.3
1986-87	30.6
1987-88	20.5
1988-89	34.5
1984-89	28.3

Also serving to minimize the cost to the states of expansions for pregnant women and children is the fact that. in many instances. prenatal care and related services already were provided. either under previous Medicaid options or using state and local funds. A 1989 study found that 43 states had implemented 1984-89 expansions targeting pregnant women and children.[15] Of these. 17 financed the expansions in whole or in part by transferring state funds from their public health/maternal and child health budgets to their Medicaid budgets.[16] The states have a clear—and acknowledged—incentive to maximize federal matching funds by means of such transfers. but we have been unable to document the dollar amount involved nationwide.[17]

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[14] However. the increase associated with this group was slightly higher than one-third of the total growth for 1988-89.

[15] Fox Health Policy Consultants Inc.. State Strategies for Financing Medicaid Expansions to Meet the Needs of Children and Pregnant Women. Aug. 1989

[16] Our case study states differed in this regard. Maine made such a transfer. while South Carolina did not.

[17] States generally employed a combination of funding approaches for these expansions. Thirty-three states used new appropriations. in conjunction with transfers between programs. as part of their funding mechanism.

10/11/91

Mr. K., age 46.

Mr. K. suffers with Colo-rectal cancer with bony destruction of the sacrum and coccyx on the right side resulting in surgery with a colostomy 3 months ago. He is now undergoing chemotherapy.

Mr. K. is functionally illiterate, and has always been a laborer.

His Medicaid application has been pending since 8/30/91. His GA and GA-Medical have been terminated.

Mr. B., age 32.

Mr. B. was hospitalized with a collapsed lung and pneumonia in June, 1991. In addition, he suffers from a seizure disorder which is not controlled by medication.

He requires heavy doses of antiseizure medications daily.

Mr. B. does not drive due to recurring seizures and has a slow reflex response due to medication.

His Medicaid application has been pending since July 1991. His GA and GA-Medical have been terminated.

Mrs. P., age 60.

Mrs. P. was hospitalized in March 1991, for chest pain. She is an insulin dependent diabetic who also suffers from high blood pressure, severe arthritis, and reflux disease.

Mrs. P. does not read, write, or speak English, nor does she read or write Spanish. She only speaks Spanish. She never went to school and never worked outside the home.

Her Medicaid application has been pending since 5/6/91. Her GA and GA-Medical have been terminated.

Mr. A., age 49.

Mr. A. was hospitalized in June, 1991, for cancer in his left kidney resulting in surgery to remove the tumor and his spleen, followed by pneumonia. In addition, he is an insulin dependent diabetic and has high blood pressure.

He has had back problems since a severe fall at age 18. He now has difficulty standing after he's been sitting for awhile.

He has been on antibiotics for recurring lung infections since his surgery. Mr. A's regular physician is refusing to see him because he does not have Medicaid coverage.

He has a 10th grade education and has always done farm work or trash routes.

Ms. M., age 43.

Ms. M. has had frequent hospitalizations and emergency room admissions for complications related to her insulin dependent diabetes of many years.

She has constant numbness in her hands and feet; her feet are classic diabetic neuropathy changes, as are her hands. Her feet swell and she has problems buttoning her clothes and holding items in her hands.

She has had chronic diarrhea for nine years, and has episodes of blurred vision, both complications of her diabetes. She has a 9th grade education.

Her Medicaid application has been pending for 20 months. We are now awaiting a decision from the Bureau of Administrative Hearings. Her GA and GA-Medical have been terminated.

Mr. J. A., age 56

Mr. J. A. is a resident of an Adult Foster Care Home following surgery to replace a heart valve. He suffered fainting spells following the surgery and was no longer able to care for himself.

Mr. J. A. has severe emphysema, he requires heart medications, blood thinning drugs, and continued treatment for both his heart and his emphysema. He is currently out of medications.

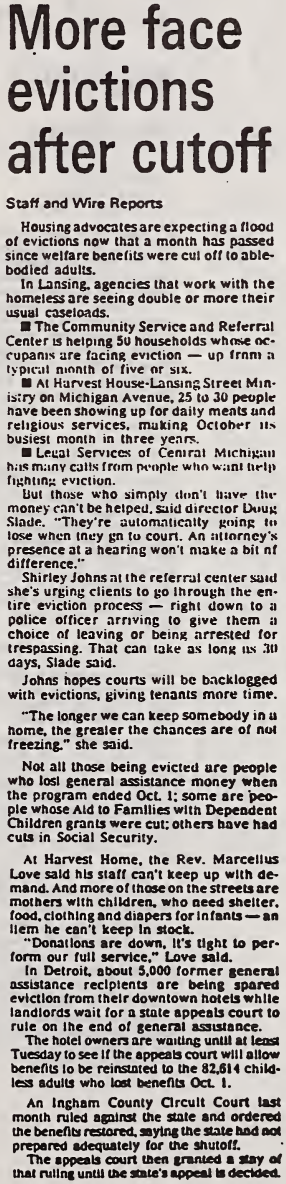
His application for Medical Assistance was filed 5/21/91 and is still pending. We understand that his GA was terminated despite the fact that he is a resident of an Adult Foster Care Home.

Mr. J. B., age 55

Mr. J. B. was hospitalized in July and August 1991 for chest pain which was diagnosed as unstable angina. He also has diabetes and a possible malignancy.

He requires three prescription drugs for his heart and one for his diabetes. His application for medical assistance is pending. Mr. J. B.'s GA has been terminated.

"More face evictions after cutoff,"
Lansing State Journal,
Fri., Nov. 1, 1991, at 1A.



More face evictions after cutoff

Staff and Wire Reports

Housing advocates are expecting a flood of evictions now that a month has passed since welfare benefits were cut off to able-bodied adults.

In Lansing, agencies that work with the homeless are seeing double or more their usual caseloads.

- The Community Service and Referral Center is helping 50 households whose occupants are facing eviction — up from a typical month of five or six.
- At Harvest House-Lansing Street Ministry on Michigan Avenue, 25 to 30 people have been showing up for daily meals and religious services, making October its busiest month in three years.
- Legal Services of Central Michigan has many calls from people who want help fighting eviction.

But those who simply don't have the money can't be helped, said director Doug Slade. "They're automatically going to lose when they go to court. An attorney's presence at a hearing won't make a bit of difference."

Shirley Johns at the referral center said she's urging clients to go through the entire eviction process — right down to a police officer arriving to give them a choice of leaving or being arrested for trespassing. That can take as long as 30 days, Slade said.

Johns hopes courts will be backlogged with evictions, giving tenants more time.

"The longer we can keep somebody in a home, the greater the chances are of not freezing," she said.

Not all those being evicted are people who lost general assistance money when the program ended Oct. 1; some are people whose Aid to Families with Dependent Children grants were cut; others have had cuts in Social Security.

At Harvest Home, the Rev. Marcellus Love said his staff can't keep up with demand. And more of those on the streets are mothers with children, who need shelter, food, clothing and diapers for infants — an item he can't keep in stock.

"Donations are down, it's tight to perform our full service," Love said.

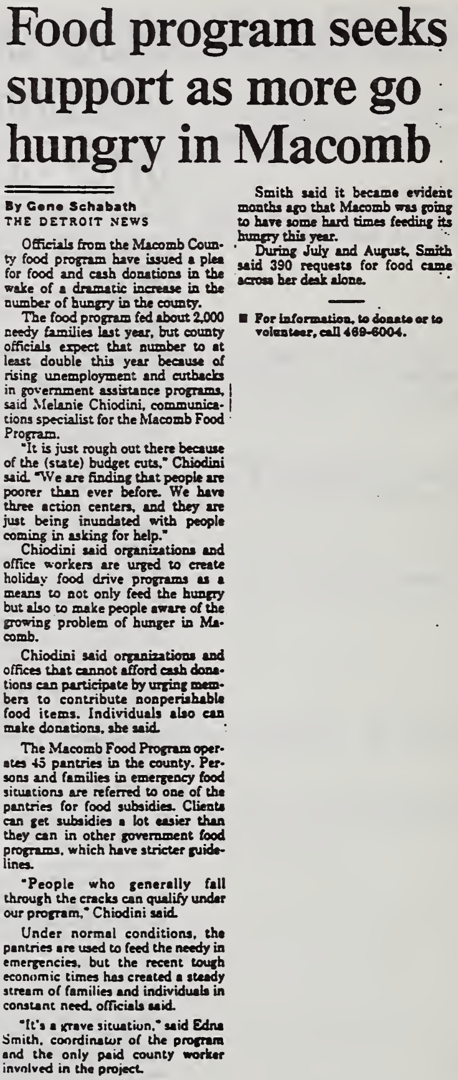
In Detroit, about 5,000 former general assistance recipients are being spared eviction from their downtown hotels while landlords wait for a state appeals court to rule on the end of general assistance.

The hotel owners are waiting until at least Tuesday to see if the appeals court will allow benefits to be reinstated to the 82,614 childless adults who lost benefits Oct. 1.

An Ingham County Circuit Court last month ruled against the state and ordered the benefits restored, saying the state had not prepared adequately for the shutoff.

The appeals court then granted a stay of that ruling until the state's appeal is decided.

Schabath, G.,
"Food program seeks support as more go hungry in Macomb," The Detroit News, Wed., Oct. 23, 1991, at 5B.



Food program seeks support as more go hungry in Macomb

By Gene Schabath
THE DETROIT NEWS

Officials from the Macomb County food program have issued a plea for food and cash donations in the wake of a dramatic increase in the number of hungry in the county.

The food program fed about 2,000 needy families last year, but county officials expect that number to at least double this year because of rising unemployment and cutbacks in government assistance programs, said Melanie Chiodini, communications specialist for the Macomb Food Program.

"It is just rough out there because of the (state) budget cuts," Chiodini said. "We are finding that people are poorer than ever before. We have three action centers, and they are just being inundated with people coming in asking for help."

Chiodini said organizations and office workers are urged to create holiday food drive programs as a means to not only feed the hungry but also to make people aware of the growing problem of hunger in Macomb.

Chiodini said organizations and offices that cannot afford cash donations can participate by urging members to contribute nonperishable food items. Individuals also can make donations, she said.

The Macomb Food Program operates 45 pantries in the county. Persons and families in emergency food situations are referred to one of the pantries for food subsidies. Clients can get subsidies a lot easier than they can in other government food programs, which have stricter guidelines.

"People who generally fall through the cracks can qualify under our program," Chiodini said.

Under normal conditions, the pantries are used to feed the needy in emergencies, but the recent tough economic times has created a steady stream of families and individuals in constant need, officials said.

"It's a grave situation," said Edna Smith, coordinator of the program and the only paid county worker involved in the project.

Smith said it became evident months ago that Macomb was going to have some hard times feeding its hungry this year.

During July and August, Smith said 390 requests for food came across her desk alone.

- **For information, to donate or to volunteer, call 469-6004.**

The Detroit News, Tue., Oct. 22, 1991, at 1B.

Charities fear impact of welfare cuts

- **Overloaded:** Social service groups say they won't be able to meet the demand this winter.
- **Politicians:** Fight for public opinion. Page **2B**

By Kim Trent
THE DETROIT NEWS

Representatives of Detroit social service agencies told the City Council Monday the state's elimination of general assistance and other funding has left them overloaded and unable to meet growing demands.

Richard Quinn of the Detroit Rescue Mission Ministries, said his group's Third Avenue mission in the Cass Corridor has fed an average of 90 to 100 more transients at its daily dinners since the welfare cutoff Oct. 1.

"What happens when the winter really comes and we start getting maybe three or four hundred (more) people?" asked Quinn, who is the mission's grants manager.

"I don't think we can handle it, and I think all the shelters will be in the same position we are."

In response, Cuuncilman Mel Ravitz proposed that the council invite Gov. John Engler and state legislative leaders to Detroit for tours of the city's social services agencies.

"I find it difficult to believe that those up in Lansing ...know what they have done," Ravitz said. "I can't believe that these people would, if they understood the consequences of their actions, have done what they've done."

Several other groups told the council that the elimination of general assistance welfare benefits and other emergency funding have interfered significantly with their ability to serve poor people.

The Rev. Ann Johnson, executive director of the Eastside Emergency Center, predicted her organization's soup kitchen and emergency shelter will have to turn away hundreds of homeless people in coming months.

"I have decided to run for governor of the state of Michigan. I feel that with the way things are going it can't get any worse," Ms. Johnson said. "I'm told this is the richest country in the world, but today I stand here pleading for justice for men, women and children."

State Rep. Joe Young, Sr., a vocal opponent of the cuts, praised Ravitz for his proposal but said he was pessimistic about the number of leaders who would accept the invitation.

"I think it will expose the public to what's really going on here," Young said. "I don't think they'll come, but if they don't show up it will make them look bad."

Detroit Free Press, Tue., Oct. 22, 1991, at 14A.

End of welfare puts soup kitchens in demand

Coalition says many on streets go hungry

BY PATRICIA CHARGOT
AND WILLIAM KLEINKNECHT
Free Press Staff Writers

Detroit area soup kitchens have been overwhelmed with requests for emergency food since the state ended General Assistance welfare Oct. 1, a city official and several providers said Monday.

In what appears to be the largest single jump in hunger since ex-Gov. William Milliken declared "a human emergency" in 1982, the need for food in the Detroit area has doubled — even tripled in some cases — at many soup kitchens and food pantries, they said.

At a Detroit City Council hearing, Diane Bernard, an official of the Hunger Action Coalition, an umbrella group for 300 food providers in the tri-county area, said the need for food has skyrocketed since more than 90,000 people lost their benefits. Almost half of those people are in Wayne County.

Bernard said a food provider in Romulus has seen a doubling of the number of people it feeds, and one in Detroit has seen a tripling. She did not name the providers.

Also at the hearing, Richard Quinn, grants manager for the Detroit Rescue Mission, an 83-year-old facility in the Cass Corridor, said the number of dinners served at the mission is averaging about 190 — up from about 70 to 80 just a few weeks ago. On one recent night, 255 people came to the mission for dinner, he said.

"I don't know if we can handle it," Quinn said.

In Lansing, the director of Detroit's Neighborhood Services Department told a House Committee that soup kitchens have been overwhelmed because former GA clients are selling their food stamps to try to pay rent.

"They're selling them for 30 cents on the dollar,' said Cassandra Smith-Grey, who oversees the distribution of government surplus food and works closely with emergency food and shelter providers.

"They're all getting $111 in food stamps, and they're trying to pay for their basic needs," she said. "They're trying to live on that."

Grey said the Capuchin Community Center — the city's largest daily feeding program by far, serving more than 1,300 meals a day — had been "overwhelmed," and was willing to provide the House Appropriations Committee with written testimony on the crisis.

ATTACHMENT A

DECLARATION OF JANE DOE

I, Jane Doe, under penalty of perjury, say:

1. I live with my three children, ages one, two and four in a rented home in Detroit.

2. I have lived at this address for the past three years.

3. My rent is $250.00 per month and does not include heat, electricity or water.

4. The sole source of income for myself and my three children is through Aid to Families with Dependant Children (AFDC).

5. My rent, electricity and gas payments are directly vendored by the Department of Social Services.

6. After these payments are deducted, I am receiving a cash grant for the month of May in the amount of $44.00 every two weeks.

7. This is a reduction from my March and April grant amounts which were $55.00 every two weeks.

8. Prior to the grant reduction in March, I received $125.00 every two weeks, after the rent and utilities were vendored.

9. I do not have a phone or a car. I have been struggling to survive since March.

10. Two weeks ago my water was shut-off.

11. When I contacted the Detroit Water Board, I was told that the water bill was approximately $400.00 and that I would have to pay that amount plus a $10.00 service charge before the water services could be restored. The Water Board would not agree to accept a payment plan.

12. There is no way I can afford to pay this amount out of my current monthly cash assistance grant.

13. I went to the Department of Social Services for emergency assistance and was informed that the Department no longer pays these bills.

14. I called my landlord and asked him if he would pay the bill so that I could pay him over time, but he said that payment for water was my responsibility and refused to pay the bill.

15. Since then, I have been referred to a number of social service agencies, none of which were able to help me.

16. I went to the Neighborhood Services Department for the City of Detroit on Six Mile Road and Hubbard and was told that there was nothing they could do to help me.

17. I called the Mayor's hotline and was told the same thing; they could not help me.

18. I contacted the Salvation Army. THey were not able to help and warned me that if I was not able to get the water turned back on, I could lose my children.

19. I called the St. Vincent DePaul Society but they had run out of money and could not help me.

20. I called Catholic Social Services and they could not assist me.

21. No one has been able to help us, except my neighbor across the street who had been providing me with at least 2-liter pop bottles of water every day.

22. I use this water to flush the toilet, wash dishes, sponge

bathe my children and myself, cook and clean.

23. Since the City shut-off the water, the pipe in the ground in front of my house has been leaking and I watch the water run across the walkway, down the driveway and into the sewer. I've called the Water Board three times and they say they will send someone out, but no one has come. I have seen water trucks in the neighborhood often recently, but none have come to repair the leaking pipe in front of my house.

24. The week that the water was shut-off, my four year old son, Anthony and I developed chicken pox.

25. My doctor recommended that I give my son aveeno oatmeal baths to relieve the itching. Because I had no water, the best I could do was to give him sponge baths, filling a plastic basin with water borrowed from my neighbor in pop bottles.

26. Two of my children, the one year old and the two year old are still in diapers.

27. Until May 3, I had three in diapers.

28. Wednesday of last week, I buried my two month old daughter, who I lost to sudden infant crib death.

29. I don't know how I can continue. I am depressed and grieving. I have not been able to eat. My doctor prescribed medication yesterday to help me sleep. I can't believe what has happened to me. I keep praying for help. I know I must be strong for my children. The four-year old asks me why we have to borrow water from the neighbors and why he can't take a bath. I try to

hide my shame because I don't want him to feel it or to know how worried I am.

30. For the past two days, the 80 degree weather has made living without running water even harder.

I declare that the statements above are true to the best of my information, knowledge and belief.

Dated: 5-15-91

Jane Doe
JANE DOE

aa:\water\doe.dec

DECLARATION OF JOHN DOE

JOHN DOE, under penalty of perjury, says as follows:

1. I am using the name of John Doe in this statement because I was forced to sell my food stamps which is illegal and I do not want to be prosecuted. I am 42 years old.

2. I live at 678 Selden, in the Cass Corridor area of Detroit.

3. I have lived at this address for the past 8 years. I share my apartment with another tenant. The apartment has one room and a bathroom. Until October 1, 1991, we were both receiving GA.

4. Since GA has been terminated, and after the GA reductions in August, the manager of the building, whose name is pronounce "John Vaugnville" has been extorting food stamps from tenants in the building.

5. Since all of the mail for the building is delivered to the manager, he is able to hold our food stamp cards. For the past three months, he has been driving tenants to the food stamp distribution center on Grand River to collect our food stamps. Then he forces us to sell the food stamps on the street in front of the distribution center while he waits in the car. We get 70 cents for every dollar of food stamps. This month I collected $77 for $111 in food stamps. We are then forced to turn over every penny to him for rent. Because he forces several tenants to live together in these two-room apartments, he is able to collect full rent this way.

6. When I gave the manager my food stamp money this month, I asked him if I could have a couple of dollars back to buy a birthday cake for my son who turned 10 on October 11. John became violent and with his fist, fractured my face beyond repair. I was hospitalized, as a result.

7. John is able to control the tenants with an electric cattle prod. The prod is like a long pipe with an electric shocker on the end of it. He is threatening us with it. I have been the victim of his cattle prod on more than one occasion. Once I was hospitalized for a spleen injury because of the cattle prod. He hit me with it because I invited some of my friends who are black into my apartment.

8. I have filed police reports because of these incidents but nothing has been done.

9. I have no income and no food stamps to purchase food. I suffer from sclerosis of the liver, pancreatism, seizures and I had a heart attack a few years ago. I am an alcoholic, and have been hospitalized and received in-patient treatment at various times in the past.

10. Before I gave the information for this affidavit, I had never heard of State Disability Assistance. I will apply for it. I believe I am eligible because I receive a monthly medical card. I received one for October, 1991, but I did not receive a GA or SDA check.

I declare that the statements above are true to the best of my information, knowledge and belief.

10-18-91
Date

John Doe
JOHN DOE

DECLARATION OF JOHN FERMAN

1. I am a 41 year old resident of Oak Park, Michigan. I was receiving General Assistance until I was cut off on October 1, 1991. I now receive neither benefits, nor medical insurance. The only income I have is food stamps.

2. I may be evicted from my home at any time. I have already received two seven-day notices which I have been able to stall by putting down small amounts of money. Since I owe $1200 and haven't paid my rent fully in over three months, it could happen at any time and will by November 1st at the latest.

3. I am HIV positive and have not been able to see my doctor who I am suppose to see monthly. I am also suppose to take AZT, Bactrim, Dilantin and Motrin daily. Since I stopped taking my medicine I have been in a great deal of pain and have felt very tired. I am worried about the long term effects of not caring for my medical needs.

4. I have received a shutoff notice for my telephone and am due to receive a shutoff notice for my electricity any day.

5. I also care for my partner who is disabled. We will both be homeless very soon. He was cut off GA and has no other sources of income either. We have no where to go when we are evicted.

6. I have pending claims for SDA and Social Security Disability but have no idea when, if ever, these will come through. Even if they do approve me, it will probably be long after we become homeless.

7. I applied for General Assistance in May. When DSS did

not respond to my request for GA, I applied for a hearing. I finally had a pre-hearing conference and was approved for GA in July, 1991. I feel this was an unduly long time to wait for approval.

8. The fact that I am going to be sick with no roof over my head makes me very anxious and angry.

I declare that the statements above are true to the best of my information, knowledge and belief.

10-18-91
DATE

John B. Ferman
JOHN FERMAN

B2:\saxon\Ferman.dec

DECLARATION OF PAUL KNOBLOCH

1. I am a 57 year old former recipient of General Assistance. I was cut off general assistance on October 1, 1991. I am a resident of Detroit and have lived in this area all of my life.

2. I have a pending application for both SDA and Social Security Disability. I have no income. I live in a hotel and could be evicted at any time. I am already behind in my rent and am depending on the kindness of my landlady not to throw me out into the street. I have never been married and have no children or other relatives that I can depend on to give me a place to stay when I am evicted.

3. I have many health problems and take five different medications. I have congestive heart failure, alcohol liver disease and a number of problems with my arteries. I have been experiencing chest pains very often now and my heart is beating very fast recently. I experienced chest pains yesterday (10/20/91). My doctor wrote a letter for me to give to Social Security and DSS that says I cannot pull, lift, or push.

4. My last part-time job was five years ago. I am worried about what will happen when I do not get the medicines I need. I don't know what I will do if I have to be hospitalized for my heart because no one will take me without health insurance.

I declare that the statements above are true to the best of my information, knowledge and belief.

10-21-91
Date

Paul Knobloch
PAUL KNOBLOCH

DECLARATION OF GWENDOLYN DOOLEY

1. I am 41 years old, and live in Detroit, Michigan.

2. I have been working the last 20 years in four different jobs. My last job was at New York Carpet World in data entry,

3. I had to stop working because I was hospitalized for asthma and then I was in a severe car accident and injured my spine. As a result, I cannot sit, stand, or lay down for very long periods of time. I take muscle relaxers for my spine. However, I cannot afford to pay for the prescription. I currently have five pills left. I am supposed to take two per day. I am only taking one per day right now in order to make them last. I am in pain because I do not have enough medication and I am bedridden most of the day.

4. I have not worked in a year, since the hospitalization for asthma and the car accident. I was supported by General Assistance from December, 1990, until October 1, 1991.

5. Since October 1, 1991, I have not been able to pay for my medications for the asthma without GA medical assistance. I have not been able to breath well for two weeks. I cannot sleep when this happens. I have been going to my doctor weekly for asthma treatments so that I can breathe. I have a breathing machine in my home that I use four times a day. I take slobid and prednisone, and prevental for the machine, valentin inhaler, and another inhaler berintin. The slobid costs about $10.00 per pill. I take it twice per day. The prednisone costs $10.00 per pill and

I take four pills per day. The preventol for my machine costs $125.00 per box which lasts about one week. The two inhalers are $20.00 each and last about a month. I am worried that without GA medical, I will not be able to pay for these medications and that the hospitals will not take me the next time I have an asthma attack, 6. I have received an eviction notice because I cannot pay the rent and I have nowhere to go.

8. My gas is shut-off and I have no heat. I have received a water shut-off notice, and am behind in my electric bill payments.

9. I am extremely depressed and don't know what I will do. If I could work, I would.

10. I have an application for Social Security Disability pending. When I received the notice that my GA was ending, I called my worker and told her I was too sick to work. She sent me a form which I sent to my doctor who filled it out and sent it back to DSS. The form says that I am unemployable. (Exhibit) But I still am not getting state disability assistance. Saturday, the Department sent me more forms from a medical contact worker, and I received a whole new booklet, a 24 page application for assistance. Apparently, I am supposed to take the book in on October 29th, when I have an appointment with my worker, and I am supposed to take back the medical form from the medical contact worker on November 5, when I have an appointment with her. In the meantime I have no heat, my water is scheduled to be shut-off and I am likely to be evicted.

I declare that the statements above are true to the best of my information, knowledge and belief.

10-22-91
Date

Gwendolyn Dooley
GWENDOLYN DOOLEY

AFFIDAVIT

STATE OF MICHIGAN)
) ss.
COUNTY OF WASHTENAW)

ANGUS MUNRO, being sworn, says:

1) I am 60 years old.

2) I was receiving General Assistance prior to October 1, 1991.

3) Currently, I have no income. The only help I get is Food Stamps.

4) I am living in my van.

5) To get by, I donate blood for money.

6) When I was on G.A., I was buying a mobile home for $500. Now I can't pay lot rent or afford to move it anywhere. I can't finish paying on it, so the money I put into it is probably lost.

7) I tried to apply for the State Disability Assistance Program in September before my G.A. case closed. The people at the Department of Social Services told me I wouldn't be eligible and didn't even give me an application or form to take to my doctor.

8) I spoke to my food stamps caseworker on October 17, 1991, to find out if G.A. had been reinstated. She said no and didn't say anything about applying for the S.D.A. program.

9) I am disabled in that I have a plate in my ankle. I can't bend it or put any pressure on it most of the time. I also have a lot of lower back pain.

10) I used to be a carpenter but haven't been able to work since 1976.

Angus T. Munro
Angus Munro

On this 18th day of October, 1991, before me personally appeared ANGUS MUNRO, who, being duly sworn, did depose and say that the facts stated in the foregoing Affidavit are true to the best of his knowledge, information and belief, and that he signed the Affidavit as his free act and deed.

Gretchen Tarchinski
Gretchen Tarchinski, Notary Public
Washtenaw County, Michigan
My commission expires December 4, 1994.

DECLARATION OF JOELLA PERDUE

1. My name is Joella Perdue. I am 42 years old and I live in Detroit, Michigan.

2. In April, 1991, I started receiving $56.00 every two weeks in General Assistance benefits. Those benefits were reduced to $39.50 every two weeks in May, and again to $33.40 every two weeks in August, 1991. In October my General Assistance benefits were terminated.

3. I have not been able to work since 1985. I suffer from lumbar monocytes, which is polio and arthritis of the spine.

4. My gas service has been shut-off. Without heat I am in a lot of pain. The knots in my knees, and spine make walking painful.

5. I also suffer from bronchial asthma and without heat it is painful to talk.

6. Because of angina and high blood pressure, I take nitroglycerin and procardia prescriptions.

7. Without General Assistance medical assistance, I am not able to pay for these prescriptions.

8. I am on a special diet for my diabetes. I don't get enough food stamps to cover the amount and types of food I need, and I have no money to supplement the food stamps.

9. Medical transportation has been discontinued for poor persons like myself. It is difficult for me to endure bus rides to to my doctor because of the pain in my spine.

10. Although my home is paid for, I have no way to pay for the taxes or water. The water has been shut-off for non-payment. Electrical service to my home has also been discontinued.

11. I am very depressed and find it hard not to give up.

I declare that the statements above are true to the best of my information, knowledge and belief.

Oct. 22, 1991
Date

Joella Perdue
JOELLA PERDUE

DECLARATION OF MARY BAUGH

1. My name is Mary Baugh. I am 56 years old and I live in Highland Park, Michigan.

2. I worked for 21 years at Arnold Nursing Home as a nurses aide, until March, 1991, when I had a stroke and could no longer work. The nursing home had an disability insurance policy which covered me for a while. After the disability insurance money terminated, I applied for GA, but by that time, I was told the program had ended.

3. I am a diabetic and I suffer from hypertension. I take Aldomet for the hypertension and Diabenese for the diabetes. Without the Aldomet I could have another stroke. Without the Diabenes, my blood sugar goes way up. When this happens, I can't move, I get dizzy and blackout.

4. I cannot afford these medications. I have a ten day supply of Diabenes and Aldomet left. I have been skipping some days to make my medications last. Without my medication my blood sugar goes way up. When this happens I can't move. I get dizzy and blackout.

4. I need to eat three meals a day and one snack. I get $111.00 in food stamps. This does not cover the amount of food I need. Without the right amount of food I become dizzy and nauseous.

5. I have received a seven-day eviction notice and I have no place to go, if I am evicted. I have no family or friends who can take me in. I am worried that I will wind up in the streets.

6. I had surgery on my right eye two weeks ago, but I still can't see very well. I am scheduled to have surgery on my left eye on Tuesday, October 22, 1991. Then, another surgery will be scheduled for my right eye again, because the first surgery did not work. I am having problems with my eyes because of the diabetes.

7. I tried to apply for state disability assistance, but the Department of Social Services would not let me apply because I did not have an appointment when I went in. I currently have a Social Security Disability application pending with the federal government.

I declare that the statements above are true to the best of my information, knowledge and belief.

Date

MARY BAUGH

B2\saxon\Baugh.dec

DECLARATION OF JOSEPH MONTOYA

1. I am 49 years old and I live in Detroit, Michigan.

2. I suffer from diabetes, osteoarthritis, heart problems and high blood pressure.

3. I am unable to work, and until October 1, 1991, I was supported by General Assistance.

4. I have no medical insurance, but fortunately the Southwest Hospital and Medical Center is still honoring my Countycare medical card for October, although payments for GA medical assistance terminated October 1 also. I am worried that soon (the end of this month) my doctors will stop honoring the card because they will not be paid. In addition, Southwest Hospital which is the medical center that I am required to go to under CountyCare medical program, is closing. The emergency room has already closed and the hospital is operating with a skeletal staff. I do not know whether or not I will be able to see my doctor on Friday. In addition, without any income, I have no money to pay the 50-cent co-pay for my prescriptions that Countycare requires. I am currently treated with 24 different medications.

5. I take insulin injections twice a day. Without the insulin I could enter into a diabetic coma, and die.

6. I also take medication for my high blood pressure, and coronary problems, including angina. Without the medication I risk a stroke or heart attack.

7. I am on the verge of complete renal disfunction. This means that my kidneys could fail at any time and that I will

require regular dialysis treatments, without which I will die.

8. Because of the diabetes, my feet are hemorrhaging. Also my thumb has begun to hemorrhage. I cannot afford proper daily treatment for these conditions. Without appropriate treatment, gangrene is certain to settle in, which may require amputation. Because the loss of my toenails, I am unable to wear shoes.

9. Because of edema and poor circulation, my feet and legs swell, causing pain and discomfort. My hands, elbows, shoulder, knees, ankles are swollen due to osteoarthritis.

10. I suffer from bleeding hemorrhoids which I am unable to treat because I have no money for prescriptions or over-the-counter medications.

11. I was served with a seven-day eviction notice on October 3, 1991.

12. Because of the 29% reduction in GA benefits in August and September, My phone bill is two-months in arrears. I need my phone for medical emergencies. Last year, a friend used it to call EMS because I was in a diabetic coma. I would have died without the phone.

13. Because I am diabetic, I am on a special diet and need to eat properly balanced meals. I receive $111.00 in food stamps per month which allows me about $3.50 for food per day, which is not enough.

14. I have no family in the area that I can go to for help.

15. I haven't worked since 1975, when I was employed as a

driver for Photomat corporation. I was forced to give up my job because I became to sick to work.

16. I have an application for SSI pending and I applied for State Disability Assistance in August, 1991. I am waiting for decisions from the state and from the federal government.

17. I am extremely depressed and feel like giving up. I do not know where I will go when I am evicted. I cannot live in the streets and I understand the shelters are full.

I declare that the statements above are true to the best of my information, knowledge and belief.

10-22-91 Joseph Montoya

Date JOSEPH MONTOYA

B2\saxon\montoya.dec

DECLARATION OF KAREN MASSINGILLE

KAREN MASSINGILLE, under penalty of perjury, says as follows:

1. I am the Director of the Senior Citizen Case Coordination and Support Program at Project Scout, located in the Cass Corridor in Detroit, Michigan.

2. The program is funded by the Detroit Area Agency on Aging to provide various supportive services to the frail elderly in the Cass Corridor. These services include connecting seniors with meals, home help, medical care, transportation, and housing placement, as needed.

3. There are approximately 3,000 seniors who live in the Cass Corridor area of Detroit.

4. At any given time, we are serving approximately 200 seniors, ages 60 or older.

5. Of those seniors who are in the 60-64 age group, approximately 50% are supported by GA.

6. Last week, after notices went out to approximately 97,000 GA recipients state-wide, the number of new seniors who came in requesting assistance doubled. The seven seniors, supported by GA who contacted our office for assistance were extremely panicked. I am able to describe the situations of some of these seniors as follows:

7. One senior, aged 63, lost GA October 1 and came into our office. He was limping when he came in. I am attempting to locate housing for him by October 17 which is the date he must be out of the housing he has rented. On Thursday, October 3, 1991, I contacted his DSS worker, Mr. Blackwell, at the Medbury Office in Detroit. We discussed this senior's eligibility for SDA and how he could apply. Mr. Blackwell acknowledged that the senior was 63 years old and suffered from arthritis. However, he said the SDA program was changing daily. He even insisted that it had a new name, SAD. He informed me that I could come to the office to pick up a medical form that the senior should take to a doctor. I immediately went to the office and picked up the form. While at the DSS office, I also asked the worker about the senior's eligibility for ENP assistance so that he could move and store his belongings while he was waiting for a decision on his eligibility for disability assistance. I was told by Mr. Blackwell that there was no ENP program. I have until the 17th to try to locate housing for this senior, which I will not be able to do if he has no income, or ability to pay a security deposit and first months rent.

8. Senior #2 is a 60-year old woman, named "Mary" who contacted me after she received her GA termination notice on Tuesday, September 24. She appeared to be extremely distraught. She was twisting a kleenex in her hand and mumbling repeately "Three days if I can only stay three days. Three more days, if I can only stay three days." She could not answer any of my

questions and was not lucid. I referred her to a local shelter. On Wednesday, I contacted Adult Protective Services of DSS. I explained Mary's situation and also informed them that because her GA was terminated and she had no income I could not locate housing for her. They did not mention SDA. Instead, someone from Protective Services call me back on Thursday afternoon and advised me to take Mary to the crisis center at Receiving Hospital in Detroit. I informed them that I did not believe she would go voluntarily. They told me they would call back. On Friday, the same DSS protective services worker called me, and told me that another worker had been previously assigned to "Mary's" case. The worker acknowledge that the assigned worker was on vacation and suggested that I contact the supervisor on Monday.

9. In the meantime, "Mary" 's landlord came to my office on Friday looking for her. The landlord presented me with three vials of medication for "Mary". One bottle was labelled "haldol"; another was labelled "procardia", and I do not remember the label on the third vial. I was not able to locate Mary at the shelter. I made other attempts to locate her at the shelter on Saturday and Monday, but she was not there. On the following Thursday, October 3, I ran into Mary on the streets. She was extremely disturbed, and incommunicable. She would not take her medication from me.

10. Because I am involved in housing placement, I have seen landlords who rent to GA recipients closing buildings down. This presents additional placement problems for our office since elderly persons with other income sources are threatened with displacement when the buildings are closed. In one case, tenants are simply being locked out by a building owner. These tenants are homeless instantly without any notice or opportunity to locate temporary shelter.

I declare that the statements above are true to the best of my information, knowledge, and belief.

Karen Massingille

Karen Massingille

DATED: October 2, 1991

DECLARATION OF RAYMOND HALEY

Raymond Haley, under penalty of perjury, says as follows:

1. I am currently living in the Homeless Union Drop-In Center in the Cass Corridor in Detroit during the day and at Sacred Heart Catholic Church in the Interfaith Hopitality Ministries Rotating Shelter in the evenings. I have been living like this for six days since I was forced to leave the Lillibridge Hotel on East Jefferson in Detroit on the morning of October 1, 1991.

2. Prior to October 1, I was receiving GA and my rent for my hotel room at the Lillibridge was vendored directly to the hotel owner. My entire grant of $174 per month was vendored to pay the rent at the hotel.

3. I have a workers compensation claim pending for a head injury I received on the job in November, 1990.

4. When I received a notice about the GA disability supplement in July, I went to DSS to apply for it. When I went in to apply, I told the worker about my workers' compensation claim and informed her that I wanted to apply for the state disability assistance supplement so that my check would not be cut again. It had already been cut from $246 to $206 in March and my rent was $200 at the hotel. The DSS worker had me sign a form agreeing to repay my GA grant if and when the workers compensation claim is paid. However, she did not give me any papers to take to a doctor

to apply for the supplement, or tell me how to apply for the supplement.

5. In August, my grant was cut to $174 and my landlord agreed to accept the lower vendored amount of $174 so I converted the vendor to $174 and vendored my entire grant amount.

6. On September 23 I received a notice from DSS that my GA grant was terminated effective October 1.

7. I went to the DSS office at 7608 Ker Cheval ~~Townsen~~d in Detroit on September 24 and no one would see me because I did not have an appointment. I waited all day until they closed and was told to come back the next day.

8. I went back to the same DSS office the following day, September 25, and my worker gave me a DSS-49 form and told me to have it filled out by a doctor and to bring it back to her.

9. I have not been able to obtain an appointment with my doctor to complete the form. Because I do not have Medicaid, I am on the DSS County-Care Health Source medical program for GA recipients at the Mercy Family Clinic in Detroit. I cannot get an appointment there until October 17.

11. In the meantime, because I had to leave the hotel to avoid being locked out, I am staying at the Homeless Union Drop-In Center during the day and the Rotating Shelter at Sacred Heart Catholic Church at night. It is noisy and I am staying with 70 strangers, some with obvious mental problems. There are no beds and we all sleep in two rooms on the linoleum floor on mats at the Sacred Heart Activities Center. As of today, Sunday, October 6,

there are no churches participating in the rotating shelter for the next two weeks so we will be staying in one room at the Homeless Union Drop-in Center. I am very depressed about living like this and I see no end in sight. I keep calling my Workers' Compensation lawyer to find out how long I will have to wait, but I have not been able to get a response.

I declare that the statements above are true to the best of my information, knowledge and belief.

Raymond Haley
Raymond Haley

Dated: 10-7-91

DECLARATION OF MARY FAIRCLOTH

MARY FAIRCLOTH, under penalty of perjury, says as follows:

1. My name is Mary Faircloth. I am married to Vernon Faircloth. Vernon is 54 and I am 49.

2. We live in Atlanta, Michigan in Montmorency County.

3. Both of us were receiving General Assistance until October 1, 1991. We have been cut off GA. We have each applied for SSI within the last year, and both been denied.

4. I am an insulin-dependent diabetic. I take 26 units of Humulin-N in the morning and 13 units of Humulin-R in the evening. I also have a thyroid problem and severe osteoporrhosis. I have fractured three bones. I take synthroid for my thyroid problem and hormone therapy. I have been warned by my doctors that an interruption of hormone therapy can put me at risk for cancer.

5. Vernon has had three heart attacks and has rheumatoid arthritis of the spine. He has had surgery on his knee and needs it on his other knee. He has had surgery for carpel tunnel syndrome and has a muscular problem that affects the use of this thumb and forefinger (De Quervain's disease). He takes tenormin (for his heart), ansaid (for arthritis), voltaren (for arthritis), lopid (for high cholesterol), cytotec and zantec (for stomach problems caused by the arthritis medications).

6. On Friday, October 4, 1991 I spoke to my worker at the Montmorency Department of Social Services to seek GA disability for my husband and myself. My worker mailed medical forms to our doctors, and told me we would have to pay for the medical examination at our doctor's office since there is no more GA

Medical. He did not inform me that there is a way to get emergency medications. He did not indicate that DSS could authorize payment to obtain the medical reports that we need to demonstrate disability.

7. I will run out of my premarin (hormone therapy) and thyroid medication on Thursday.

8. My worker has told me that we should get a job and has also told me we should move in with my daughter and her husband. However, her husband is disabled, they have a small home and three sons and are barely surviving.

I declare that the statements above are true to the best of my information, knowledge, and belief.

/S/

Date

Mary Faircloth

DECLARATION OF ROBIN S.

1. I am 35 years old and live alone in St. Clair County, Michigan.

2. My only source of income is Supplemental Security Income, in the amount of $426.00 per month, and I receive $100.00 in food stamps each month.

3. I receive SSI because I am severely disabled, as I suffer from insulin dependent diabetes, ketoacidosis diabetes, peripheral neuropathy and severe chronic depression and I am presently experiencing suicidal thoughts. I understand that my illnesses could result in my death within five (5) years. I have been hospitalized numerous times in psychiatric facilities for suicide attempts and in hospitals for uncontrolled ketoacidosis, which is life threatening.

4. I take the following prescription medications daily:

Stuartnatal (vitamins)
Reglan
Pamelor (anti-depressant)
Lasix
Fioricet
Levsin
Torecan
Tegretol
Librium
Robaxin
Vancenase (nasal spray)
Zantac
Humolin/Novolin 70/30 Insulin
Humolin/Novolin Regular Insulin
Hydrocortisone cream
Cough syrup
Proventil (inhaler)
Actifed (not covered by Medicaid)

5. My 13 year old son lives with my parents in St. Clair County because I am unable to provide full-time care for him, and because he is anxious and too apprehensive to live with me. He fears that, because of my severe illnesses, he will come home and find me dead. His father was killed in an automobile accident three (3) years ago.

6. My parents, although able to care for my son, do not have adequate living space for both of us. However, they live nearby so I am able to visit with my son frequently.

7. I was hospitalized for two (2) weeks this past October in Port Huron Hospital for severe depression and suicidal thoughts.

8. At the present time, I rent a small home for $200.00 per month. I also pay for the utilities, which cost approximately as follows:

Electric: $50.00 per month in the winter, and $125.00 per month in the summer months. (I have to have air-conditioning because of my diabetes.)

Gas: $150.00 per month in the winter, and $30.00 per month in summer.

Water: I also pay for water service, which averages approximately $33.00 per month.

9. I have an outstanding water bill of $217.81. I received a water shut-off notice from the City Water Department November 20, 1991, demanding payment of $115.00 or my water service will be disconnected. A privatre charity paid a portion of the bill in

December to prevent the shut-off, however, it is due to be shut-off.

10. My gas bill is $249.97, part of which is past due, and I received a disconnect notice on January 10, 1992.

11. In the past, the Michigan Department of Social Services has assisted me with payment of utilities through the Emergency Needs Program, for which I was qualified.

12. Since several changes were made in that program, I am no longer eligible for emergency assistance.

13. I received some money for gas and electricity, however, I am not eligible for anything more this year because of the energy assistance maximum payments.

14. I contacted my caseworker at St. Clair County DSS for Emergency Assistance benefits to pay the delinquent water bill. In the past, I have received emergency needs benefits to pay overdue water and other utility bills, as I had met all the eligibility requirements effective prior to December 1, 1991.

15. I was denied emergency assistance to help pay the delinquent water bill based on a new rule called the "Affordable Housing Rule" and because of the new maximum payment.

16. As I understand it, the Department of Social Services thinks my rent is too high for me to be eligible for emergency assistance under the programs for delinquent water bills.

17. I explained to DSS that $200.00 per month is the lowest rental amount that can be found in this area.

18. On or about January 6, 1992, my request for emergency

assistance to pay the water bill was denied despite the fact that it was due to be shut-off in the near future. I received the notice on about January 22, 1992.

19. I have no other means to pay this bill.

20. It is medically necessary for me to have uninterrupted water service. I am very anxious and fearful about my future. If the water is shut off, I will be forced to leave my home without any place to go.

I declare that the above statments are true to the best of my information, knowledge and belief.

Feb 1·1992
DATE

Robin L S
ROBIN S.

Mr. DINGELL. Thank you, Ms. McParland.

Dr. Adamany, we are delighted to recognize you for your statement.

We want to express our thanks to you for your hospitality and your kindness today. We hope we can make this hearing a success. Dr. Adamany is an outstanding educator, president of this university, and a great leader in many activities, including community activities, here in the State of Michigan.

We thank you and we welcome your statement.

STATEMENT OF DAVID ADAMANY

Mr. ADAMANY. Thank you, Mr. Chairman.

I want to welcome the committee to our campus and say how much I appreciate the opportunity to testify. I have a longish statement which I will ask to be incorporated in the record, and then my oral presentation will be quite brief indeed, because I only have two real points to make.

Mr. DINGELL. Without objection, we will include your full statement in the record.

Mr. ADAMANY. Thank you.

I am here today as president of Wayne State University and as a member of the board of trustees of the Detroit Medical Center. I express the regrets of the president of the medical center that he cannot be here to join me. I want to mention that Dean Rockwell Soldel, who is the dean of our medical school, is sitting behind me and may help in response to some questions.

Wayne State University is one of the Nation's leading urban research universities, and the Wayne State Medical School, Mr. Chairman, has the largest medical student enrollment on a single campus in the United States.

Our partners in the Detroit Medical Center, which is an academic medical center, have approximately 2,200 beds. The medical center is a complex of five mainly tertiary care hospitals located on a single campus in the heart of Detroit. There will soon be a major sixth hospital there as the new veterans hospital is constructed there with us. We have one hospital in the northwest neighborhoods of the city of Detroit, one community hospital in the northwest suburbs, and various outpatient and clinic facilities.

The Detroit Medical Center is affiliated with Wayne State University but not owned by the university. Faculty physicians serve on the staff of the hospitals, and medical students as well as 700 residents are trained in the DMC. I mention this background because they help to highlight a significant mode of health care which itself is an illustration of the failure of our present health care system.

The failure of the present health care system, including Medicaid, can be illustrated by the extraordinary levels of uncompensated and undercompensated care provided by the Detroit Medical Center and Wayne State University in partnership.

I think one of the two key points now for me to bring to your attention, which will help in assessing the quality of our health care system in this country, is to point out that last year the Detroit Medical Center hospitals provided $90 million of uncompensated care to the people of this city and metropolitan area. We almost—I say almost, because there are some rare exceptions—we almost do not close our doors to the needy and the indigent in providing medical care.

In addition to the $90 million of uncompensated care provided by our medical center hospitals, another $15 million of totally uncompensated physician services were provided by the Wayne State medical faculty physicians and residents last year, and another $15 million provided in physician and resident services in undercompensated care. So that approximately $120 million of uncompensated and undercompensated service was provided to the people of this city last year by the Detroit Medical Center and Wayne State University's medical school.

Without the urban medical schools in this country like ours, and their associated hospitals, health care for the poor and disadvantaged in our cities, large cities, would simply collapse. What this demonstrates clearly is that in reality, there is neither a Federal nor State health care safety net for the most desperately needy of our citizens. If there were such a safety net, we would not be providing $90 million of hospital service and $30 million of physician services for people who have nowhere totals turn.

Now, a part of my testimony then details what you already heard, Mr. Chairman, which are many of the problems of the Medicaid system. I will not dwell on those. I do want to observe one special issue, however.

The Detroit Medical Center hospitals in a succession of years, until last year, lost $9 million, $25 million, $38 million, and $45 million a year, and brought that great health care system into substantial jeopardy.

We depleted our cash resource and we are now underfunding equipment and facilities renewal in the Detroit Medical Center because in serving the poor and the needy in this city, we drove ourselves dangerously into debt.

Largely because of the voluntary contribution program in which we have been able to participate for the last year, we had a nearly break-even year. We hope to do that again this year because of the voluntary contribution system, but we do not think our long-term prospects for being financially viable are strong absent that program.

And this underscores my first principal point, that without special emergency measures by the Federal Government, despite our very best efforts to serve our community, we are not going to be able to go forward into the future.

Now, my second point is to address you in my role as a university president, and to simply say to you that as we address the problem of health care for our people generally, and especially for the poor and disadvantaged, that we do take advantage of the great academic health centers located in our urban communities. As I pointed out previously, these health centers associated with our urban universities are already making an enormous effort to provide medical services to the indigent.

And now for a point no one wishes to hear. This is not care at the cheapest rate and the lowest quality in the academic medical centers and the Detroit Medical Center; rather, the care provided by the academic health centers in our cities is high-quality care, the kind of care that is provided by specialists at the forefront of research and clinical practice in their respective fields. It is care provided by residents being trained by leading academic physicians in the Nation. It is a quality of care that the well-off come into this city to seek.

I want to emphasize the point about the clinics operated by the Detroit Medical Center and Wayne State University physicians. There are no special clinics for the well-off or the fully insured that separate them from the poor. There are no facilities that separate white patients in the suburbs from Medicaid or non-paying patients who are disproportionately blacks or Hispanics from the city. As a patient with full coverage under Blue Cross/Blue Shield, I go to the same clinics and wait in the same waiting rooms and see the same physicians that serves our poorest citizens.

There are other advantages to using our health centers as part of the solution to the Medicare problem. These centers train M.D. students and residents, and it is vitally important for those entering the medical profession to have some direct experience in working with the disadvantaged.

It is important that they have direct experience with the special illnesses and pathologies of the poor. And it is important that the people who will be the next generation of health care providers in this society understand through practice the important challenges imposed by health care in urban settings.

Mr. Chairman, I would make the same comments about research: It also adds to health care costs. If we are going to conquer those illnesses and medical injuries that are especially present in urban centers and among the poor, then academic physicians who conduct the vast majority of this Nation's medical research, must know these threats to health through their practice, and must help address them through research among urban populations.

This kind of medical care is not, as I have said before, the kind of health care service provided by private or public insurance programs whose sole measure of success is low cost and high volume. Providing first-class medical care to our fellow citizens who are poor or disadvantaged, training physicians to work with these patients and instilling a commitment among physicians to the poor and the disadvantaged and conducting research that will help us address the special pathologies of the urban poor is not the lowest-dollar medical care that distant planners and policy analysts might concede. At the same time, it need not be the same high-cost medical care that so many of our insurance plans now support.

I would suggest that we move forward in steps. I would suggest that the Federal Government and the States should directly fund managed care programs on the model of HMO's that would serve the urban poor and that would be built around, and if possible, managed by urban academic health centers, public and private hospitals, public and private medical schools.

I believe we would find means to provide quality care at reasonable rates. We would soon discover that academic hospitals and physicians could engage in preventive programs, for which there is now, of course, no budgetary support, in preventive programs that would lower overall health care costs.

After all, if a poor person is continuously affiliated with the same health care institution and the same group of physicians, they will not be driven to seek care only when illness becomes extreme, and to seek it mainly through emergency rooms where costs are highest.

Moreover, the present network of urban hospitals, especially the urban academic hospitals, already have the capacity to provide a high volume of care because they have the facilities and the equipment in place.

Well, I have some additional comments, Mr. Chairman, in my written statement, but I want to point out that many of the solutions to the problem now being proposed would mistakenly turn their backs on the great urban health centers in our distressed cities that are already deeply involved in providing care for the disadvantaged.

I believe instead we should build on that network of existing health facilities, those dedicated residents and faculty members already providing care to the poor at little or no reimbursement. This cannot be the cheapest care we can achieve, but a mature and civilized society does not determine its health care only on the basis of cost.

I appreciate the opportunity to appear today, and I hope we have shed some light on a little different aspect of care for those who have no other place to turn, and perhaps offered at least a window of potential for serving our disadvantaged populations through existing networks of physicians and hospitals who are already participating in this responsibility.

[Testimony resumes on p. 251.]

[The prepared statement of Mr. Adamany follows:]

Testimony of David Adamany
President, Wayne State University

Subcommittee on Oversight and Investigations
of the
Committee on Energy and Commerce
United States House of Representatives

February 28, 1992

Mr. Chair, other members of the Committee, and members of Michigan delegation, I am David Adamany, the President of Wayne State University and a member of the Board of Trustees of the Detroit Medical Center.

Wayne State University is one of the nation's leading urban research universities. The Wayne State Medical School has the largest medical student enrollment on a single-campus in the United States. The Detroit Medical Center (DMC) is an academic medical center with approximately 2,200 beds. It consists of a complex of five tertiary care hospitals located on a single campus in the heart of Detroit, one hospital in northwest Detroit, one community hospital in the northwest suburbs and various outpatient and clinic facilities. The Detroit Medical Center is affiliated with Wayne State

University, but is not owned by the University. Faculty physicians serve on the staff in DMC hospitals, and medical students as well as 700 residents are trained in the DMC.

The failure of our present health care system, including Medicaid, can be illustrated by the extraordinary levels of uncompensated and undercompensated care provided by the Detroit Medical Center/Wayne State University partnership. Last year more than $90 million of totally uncompensated care was provided by the Detroit Medical Center. Another $15 million of totally uncompensated physician services was provided by Wayne State faculty physicians and residents, with still another $15 million in undercompensated health care, where reimbursement fell short of health delivery costs, also provided by these physicians and residents. Without our urban medical schools and associated hospitals, health care for the poor and disadvantaged in our large cities would simply collapse. That demonstrates clearly that there is neither a Federal or state health care safety net for the most desperately needy among our fellow citizens.

The Medicaid program is by far the nation's most important program for providing financial access to health care for our nation's low income population. In Michigan, approximately 1,000,000 citizens depend on Medicaid coverage to secure needed health services -- services which they could not possibly afford without this vital program. However, despite its successes, the current design of the Medicaid program has a number of inadequacies.

From its inception, Medicaid eligibility criteria has relied on a concept of the "deserving poor." Presently, in order to qualify for Medicaid coverage, a person must meet income standards which have eroded to the point where millions of people below the Federal government's recognized poverty level make too much money to qualify. In Michigan, which is one of the more generous states, only about 70 percent of people living below the poverty level qualify for Medicaid. In addition, recipients can qualify only if they have a low level of assets. This often results in people spending virtually all of their life savings prior to receiving Medicaid. This is especially difficult for senior citizens who often have limited assets to live out the remainder of their lives. Finally, categorical requirements (such as families with dependent children, over age 65, blind, or permanently disabled) result in huge differences in coverage, even for many who meet the financial eligibility standards.

Simply stated, Medicaid fails to cover a significant portion of the population living in poverty, either because of the restrictive financial eligibility standards or because of failure to fit into one of the eligibility categories. These people constitute a large portion of the 37 million Americans - over 350,000 of whom live in Wayne County - who have no health care.

In most states, Medicaid has become one of the largest and fastest growing items in the state budget. As a result, many states have asked health care providers to "subsidize" the program by establishing payment rates which fail to cover the costs of providing service. This situation has become so severe that hospitals and nursing homes in over 30 states (including

Michigan) have resorted to suing their respective state governments for failing to live up to the legal requirement of adequate payment. As a result of the legal action in Michigan, the situation has improved considerably. However, with continuing pressure on state budgets across the country, it remains to be seen whether these same difficulties will be repeated in the future.

In many respects, the problem of underpayment by Medicaid is even more severe with respect to physician services. Last year, at the direction of Congress, the Physician Payment Review Commission of the Department of Health and Human Services and the National Governors' Association conducted a study of the adequacy of Medicaid physician fees. The results of the study indicated that Medicaid physician payments in many states were significantly less than either the then-prevailing charges recognized under the Medicare program, or the fees to be paid under Medicare's new Resource-Based Relative Value Scale (RBRVS) system.

Medicaid physician payment rates, in Michigan, were, on average, 62 percent of Medicare rates. Michigan has recently improved physician payment rates by 15 percent. This was funded by the state's "voluntary contribution" program, but the rates will still be only 71 percent of Medicare levels. These rates, coupled with Michigan's medical liability climate, result in many physicians being unwilling to serve Medicaid recipients. The consequence is that Medicaid patients have limited access to physician services (including prenatal care and routine pediatric care) and often turn to hospital emergency rooms for non-emergency medical care. This is not only costly to the medical care system, but results in a lack of preventive care for a population which starts out at greater health care risk.

Federal mandates have placed an additional burden on the Medicaid system. Unfortunately, many states, including Michigan, have not been prepared to assume the additional budgetary burdens of these mandates. State officials indicate that these mandates have increased state Medicaid expenditures by hundreds of millions of dollars in recent years.

The problem with federal mandates is exacerbated in Michigan where the Federal Financial Participation (FFP) rate is relatively low (approximately 55 percent). Thus, while in some states the mandates require the state to come up with only 25 percent of the cost, our state must supply 45 percent. Furthermore, the FFP formula seems not to measure the health care needs of low income populations very well, and the time lag in adjustments to changing economic conditions tends to create a "counter-cyclical" effect--by the time the effects of a recession are reflected in the FFP formula, the recession is over.

On a more positive note, Michigan has made use of many of the optional eligibility categories, particularly those for pregnant women and children. In fact, with some additional supplementation with state funds, Michigan now offers coverage for pregnant women and young children up to 200 percent of the poverty level.

Michigan is one of those states that has utilized "voluntary contributions" to maximize the state's federal participation in the Medicaid program. The increasing costs of Medicaid programs due to health care inflation and federal mandates coupled with declining state revenues and the sincere desire by state governments to provide needed services to low-income people has resulted in many states developing programs to maximize federal participation through "voluntary contribution" and provider-specific tax programs. Last year, in an effort to put a halt to these types of programs, the Health Care Financing Administration promulgated rules which would have prohibited most, if not all, of these flexible funding mechanisms. Thankfully, Congress (along with the National Governors' Association) stepped in to negotiate a more reasonable approach.

However, with the continuation of a weak economy, combined with the legitimate demands of other state priorities, we envision the real possibility of another round of state crises in Medicaid funding when the limitations of the "Medicaid Voluntary Contribution and Provider-Specific Tax

Amendments of 1991" come into full force. These provisions will not only place state funding in jeopardy through the limits on flexible funding sources, but the act may also have a substantial impact on hospitals, like ours in the Detroit Medical Center, which provide enormous amounts of care to the indigent. These hospitals have been helped significantly by the availability of "disproportionate share hospital" payments. Without these payments, the Detroit Medical Center would not be able to continue to support the nearly $90 million of uncompensated care burden which it currently carries. The statute enacted by Congress will, in Michigan, cap those payments at their current levels. With inflation and a continuing growth of the uninsured in our community, today's disproportionate share hospital payments will not be sufficient to meet tomorrow's challenge.

Medicaid now largely covers three distinctly different populations: mothers and children, the elderly in need of long-term care, and those with mental disabilities. In Michigan, Medicaid payments for psychiatric care (through both public and private sources of care) have been one of the fastest rising components of expenditures. In many ways, these funds have replaced the state's historical responsibilities for funding. In many other states, long-term care for the elderly consumes 50 and even 60 percent of Medicaid expenditures. In Michigan, this percentage in approximately 25 percent. To a significant extent, this has enabled Michigan to continue to provide a relatively broad range of benefits to other Medicaid recipients, although this past year saw some curtailment in that ability. Michigan is able to provide these services, in part, by establishing inadequate reimbursement rates for long-term care providers (which, as I indicated earlier, ultimately forced legal action), and, in part, by severely restricting the supply of nursing care facilities through its Certificate of Need program. As the senior population continues to grow (particularly at the high end of the age spectrum) and anti-regulatory pressures grow, the demand for Medicaid dollars for long-term care in Michigan will clearly heighten, placing additional stresses on an already fragile system.

Medicaid is particularly affected by what some have called the "medicalization of social problems." We see increasing amounts of dollars under Medicaid going to treat the results of other societal failures - inadequate education, poor nutrition, violence in our neighborhoods and on our roadways, substance abuse, lack of affordable housing, and sexual practices which result in exposure to disease and in unprepared parenthood. The health care system is all too often called upon to "pick up the pieces" in an increasingly distressed urban community. Not surprisingly, the cost of health care continues to rise at alarming rates.

My remarks thus far have focused on the problems and obstacles facing our health care delivery system and, in particular, the special problems we face in our urban centers. I would now like to share with you some of the issues I hope you will take into consideration as you look to ways to improve the nation's health care system.

From my perspective as a university president, I would strongly urge that as we address health care for the poor and disadvantaged, we take advantage of the great academic health centers located in our urban communities. As I have previously pointed out, these health centers associated with our urban universities are already making enormous efforts to provide medical services to the indigent. This is not care at the cheapest rate and lowest quality. Rather, the care provided by the academic health centers in our cities is high-quality care, the kind of care that is provided by specialists at the forefront of research and clinical practice in their respective fields. It is care provided by residents being trained by the leading academic physicians in the nation. It is a quality of care that the well-off seek out.

I want to emphasize this point, Mr. Chairman. In the Detroit Medical Center and the clinics operated by Wayne State University physicians. There are no special clinics for the well-off or the fully insured that separate them from the poor, there are no facilities that segregate white patients from the suburbs from Medicaid or nonpaying patients, who are disproportionately poor blacks or Hispanics from the City. As a patient with full coverage under Blue Cross/Blue Shield, I go to the same clinics and sit in the same waiting rooms and am served by the same physicians that see our poorest and most vulnerable citizens.

There are other advantages to using our great urban academic health centers as part of the solution. They train M.D. students and residents. And it is vitally important that those who are entering the medical profession have direct experience in working with the disadvantaged, that they have direct experience with the special illnesses and pathologies of the poor, and that they understand through practice the important challenges posed by health care in urban settings.

I would make the same comments about research, Mr. Chairman. If we are going to conquer those illnesses and those medical injuries that are especially present in urban centers and among the poor, then academic physicians--who conduct the vast majority of this nation's medical research--must know these threats to health through their practice and must help address them through research among urban populations.

This kind of medical care is not, Mr. Chairman, the kind of health service provided by private or public insurance programs whose sole measure of success is low cost and high volume. Providing first class medical care to our fellow citizens who are poor or disadvantaged, training physicians to work with these patients and instilling a commitment to them among the next generation of doctors, and conducting research that will help us address the special pathologies of the urban poor is not the lowest dollar medical care that distant planners and policy analysts might conceive.

At the same time, it need not be the same high cost medical care that so many of our insurance plans now support. I would suggest that we move forward in steps. The federal government and the states should directly fund managed care programs, on the model of HMOs, that would serve the urban poor and that would be built around (and where possible, managed by) our urban academic health centers--public and private hospitals, public and private medical schools. I believe we would find means to provide quality care at reasonable rates. We would also soon discover that academic hospitals and physicians could engage in preventive programs that would lower overall health care costs. After all, if a poor person is continuously affiliated with the same health care institution and the same group of physicians, they will not be driven to seek care only when illness becomes extreme and to seek it mainly through emergency rooms, where costs are highest. Moreover, our large urban hospitals and clinics have the capacity to provide high volumes of care because they already possess the facilities and equipment. Such volumes of patients are not only cost effective, but they assure that physicians in training will develop both skill and commitment in providing care to the urban poor; and they will also provide settings in which research to address the special medical conditions of the urban poor can be effectively conducted.

It would be a mistake, in my view, to turn our backs on the great academic health centers in our distressed cities. They are already deeply involved in providing care for the disadvantaged, and we should build on what they do and what they know. This will not be the cheapest care that can be conceived, but I am not sure a mature and decent society bases its public policies on the single criterion of cost. At the same time, it will be care at reasonable costs because of managed care arrangements, high volume, the use of existing facilities, and preventive medical programs.

I hope that as we move forward in reviewing how our health care system will serve all of the poor, our federal and state governments will build alliances with our urban academic health centers by entering into experiments for managed care programs that they could administer.

In conclusion, I would like to reiterate that we are indeed in need of reforms in health care and Medicaid. However, there is much that can be salvaged from the current system. We can build upon the available infrastructure.

Perhaps the federal government can provide incentives to challenge states and academic medical centers to develop special managed care arrangements that provide high quality care while bringing health care costs under control.

Mr. Chairman, thank you for allowing me the opportunity to submit testimony regarding the issue of Medicaid and public health policy. We at Wayne State University and the Detroit Medical Center are committed to doing what we can to assist in accomplishing this important task.

Mr. **Dingell**. Thank you, Doctor.

I recognize my good friend and colleague, Mr. Upton.

Mr. **Upton**. Thank you, Mr. Chairman.

I would like to take a moment to introduce two very good friends of mine, Jim Foster, president of the Three Rivers Area Hospital, as well as Bob McDonough.

Jim Foster has played a very active part in trying to improve health care, not only in the area that I represent, Three Rivers, in St. Joe County, but really throughout our State.

I would note for those of you who are here today that Three Rivers is a community very much along the same lines as the Chairman's—a rural area, border county with Indiana and Ohio, and they have many concerns that are well addressed in this particular hearing, which focuses on rural health care.

Bob McDonough, who is former mayor of Three Rivers, current board member of the hospital, Upjohn employee, long committed to public service and good government, and also improving the quality of health care, I am sure that the remarks he may make would be important, too. I welcome you both to the committee today.

STATEMENT OF JAMES R. FOSTER

Mr. **Foster**. Thank you for asking us to share our experiences with the committee. I am Jim Foster. I am the president of Three Rivers Area Hospital. I moved to Michigan during the 1980's and I am very proud and pleased to be a part of your great State. It is a great experience for me.

We have provided written testimony, and I would ask, if I could, that that be entered into the record.

Mr. **Dingell**. Without objection.

Mr. **Foster**. Three Rivers Area Hospital is a small hospital in southwestern rural Michigan. Our economy is agricultural and small industry. We are facing a number of the same challenges that a large number of other small rural hospitals are facing in Michigan.

I think first in our list of priorities, financial viability is one of our major challenges. We have had some recent assistance in meeting that challenge in the geographic classification for Medicare, which was beneficial to us, and also in application of the board amendment to Medicare reimbursement in our State.

Second, a very important challenge for us at this time is physician availability, not only in Three Rivers but also in, I would say, all rural communities in Michigan. We recently had a hospital survey of smaller hospitals, 1991, done near the end of last year. Ninety-five percent of our hospitals in that category represent a shortage of physicians, a difficulty of having physician services within their communities.

The third thing I think is very important, and that is that we be able to move forward as our smaller hospitals in converting to provide the care that is needed so that we will be current. That conversion requires that we have a payment system, a reimbursement system, that will allow us the timeframe to plan, to execute that plan, and to exercise some run on those new investments.

A good example is an Inpatient Rehabilitation Program, which Three Rivers area hospital opened this past year. We proceeded through the initial year with very limited reimbursement, and now are at the point of being a distinct part and unit under the Medicare program, a factor that will be of value to us in providing acute preventive care within Three Rivers area.

Many of the communities in Michigan are presently depending upon such diversification in order to maintain health care in their communities. One case in point has been the substance abuse rehabilitation which in the past has been reimbursed to hospitals, being an important part of the revenue stream to that hospital. I don't know that we lost any hospitals as that reimbursement was terminated the year before last, I believe, but it was a significant factor for many of our hospitals.

Presently, long-term care is provided in some of these hospitals. And I am emphasizing hospitals because I believe them to be the center of the present health care delivery system. Without a hospital, physicians are very reticent to become associated with the community. Without a hospital, the ancillary services, the emergency services are less likely to be available in that area.

I want to just ask that you consider the impact of reducing the payment of costs in these associated or diversified services as you move toward solutions which we all seek and value.

Finally, I think that we as a hospital have as a significant part of our mission the promotion of wellness and the development of health in our area, and I would love to show you some detail on that, but I want to keep my comments very brief. But simply to say that we do a large amount of community education, of prevention and screening, and operating fitness programs, which are essentially break-even types of services, but which we think promote healthy growth and wellness concepts to our citizenry.

I would like to ask really four things, if I may make suggestions, and I understood that may be part of the agenda. First of all, I think to support those physicians who are presently established in rural areas as being the point of first contact for all citizens. I think that is very much an important point for the Medicaid population.

Furthermore, to encourage or to develop ways that new physicians will consider our areas. Just recently I spoke for the residents in Dr. Adamany's program here. He will be finishing soon. We were very anxious to have him join us to provide care at Three Rivers. But we don't have group practice in an area where there are one or two specialists in a given area. He is going to go as a physician into a group practice so he can have the security and the opportunities of that practice.

But we don't have residents presently working in small and rural hospitals. And I think that is a point that would benefit us greatly, if they became aware of the advantages of working in our type of setting.

I would ask again that we have the support of the government programs in establishing new services. Outpatient services are booming in all of our small rural hospitals. The payment rates in the Medicaid program is less than 40 cents per dollar of cost.

Mr. **Dingell**. Less than 40?

Mr. Foster. That is the information I have from a number of chief financial officers in Michigan's smaller hospitals.

Mr. Dingell. The reason I raise that is, it is computed to be 55 cents on the dollar.

Mr. Foster. Chairman Dingell, I would not argue the point with you.

Mr. Conyers. Give him a nickel or a dime.

Mr. Foster. I asked four chief financial officers last week, and they are telling me it is 37 to 39 cents on the dollar of cost in the outpatient programs for Medicaid reimbursement.

Mr. Dingell. That is outpatient?

Mr. Foster. For outpatient services.

Mr. Dingell. How about inpatient?

Mr. Foster. Inpatient, I believe, is in the neighborhood of 70 percent of our cost in inpatient care.

Mr. Dingell. So if you average the two, you come out with something around the number I gave?

Mr. Foster. That is correct.

Mr. Dingell. Forgive me.

Mr. Foster. The point is that outpatient services is the direction we need to go. Our hospital was built in 1985, 1986, and we moved in in 1987, prior to my coming. It is a real advantage to come into a brand-new facility, and I credit the board with their courage in going forward with that.

My point is we need to modify the facility in order to handle a very heavy outpatient volume. We want to go to an outpatient volume. People would prefer to be at home and come for the specific diagnostics and therapeutics that they need.

We are not encouraged to make that kind of financial reinvestment for the kind of return we are getting in this field of the program. I encourage the suggestion that cost shifting is how we are doing that. We are getting pressure on that side as well.

I am longer winded than I intended to be, and I just want to ask for two more things. One is for strong reform in the area of medical liability. It is a significant cost, and I think my friends from Michigan Hospital Association will go into that some more, but I think it is as much an intrusion for physicians especially and for other health professionals to handle, because there is such—it is such a specter. It is such a strong concern on their part.

Finally then I think—and this is something I asked for for myself in the intensity of day-to-day work in dealing with the operations of the hospital, with the possibility of expanding or diversifying. It is difficult to stay informed and in touch with new developments and new forums that are available to us.

And I would give a case in point that rural health clinics were devised and authorized, it is my understanding, in 1977. We learned of them about 2 years ago, have considered that as a possibility for St. Joseph County, but only recently have we had someone in the State government who is knowledgeable about that program and could assist us.

That would be the coordinator now of rural health clinics and federally-qualified health centers under the Department of Public Health.

Those are the things I would request, and I will stop at that point, and thank you for allowing me to come.

[Testimony resumes on p. 267.]

[The prepared statement and attachment of Mr. Foster follow:]

STATEMENT OF THREE RIVERS AREA HOSPITAL

Presented by

James R. Foster

President

I am James R. Foster, President of Three Rivers Area Hospital (TRAH), a 60 bed community hospital located approximately 20 miles south of Kalamazoo. TRAH is operated as a hospital authority under Michigan Public act 47 of the Public Acts of 1945. Included within the Hospital Authority are the City of Three Rivers and four adjacent townships. TRAH has an operating budget of approximately $17 million. Additional information concerning TRAH is presented in Attachment 2.

We appreciate the opportunity to appear before the Subcommittee today to share our insights on the challenges facing rural hospitals, and to offer our suggestions as to possible remedial action which Congress may wish to consider. I am joined by Bruno J. Masnari, Chairman of the TRAH Authority Board, Robert T. McDonough, Secretary/Treasurer of the Authority Board, and Lawrence C. Hermen, Past Authority Board Chairman and Executive Director of Community Mental Health for St. Joseph County, Michigan. Additional information on these individuals is presented in Attachment 1.

I. CHALLENGES FACING RURAL HOSPITALS IN MICHIGAN

TRAH is relatively small, but we face nearly all the challenges presently encountered by hospitals throughout the United States. In many ways, the Three Rivers area is a microcosm of the industrial heartland of this country. We are a historically prosperous community that is experiencing a deteriorating industrial base, an increasingly less affluent population, and an increasing demand for health care services due primarily to the shift in demographics to an older population.

We want to focus today in three critical challenges facing TRAH, Medicaid/Medicare reimbursement, access to health care for the uninsured, and medical liability reform.

A. Medicaid/Medicare Reimbursement

The most critical problem facing rural hospitals in Michigan is financial solvency. It is well known that Medicaid, and to a lesser extent Medicare, reimbursement levels are not adequate to support the long term viability of rural hospitals. At TRAH, our patient mix is approximately 70% Medicaid/Medicare, 25% Commercial Insurance/Blue Cross, and 5% self pay. Historically, we have been able to cover our Medicaid/Medicare shortfall by cost-shifting to commercial insurers. This was a financial fact of life which we disliked, but for which there was no alternative. As health care costs for businesses have risen during the past few years, we have found it increasingly difficult to recover the Medicaid/Medicare shortfall by cost-shifting. The result has been that most rural hospitals in Michigan have experienced deficits for the last three years. Fortunately, TRAH has been able to operate at about a "break even" level, but without an increase in Medicaid/Medicare reimbursement, the long term financial viability of our institution is very much in doubt.

B. Access to Health Care for the Uninsured

Due to the loss of manufacturing jobs in our area and both the resultant increase in unemployment and shift to lower-paying service sector jobs, we have experienced a significant increase in the number of families without medical insurance. Many of these people are working 2 or 3 part-time jobs just to make ends meet. For TRAH this has translated into an increased utilization of our Emergency Room as a provider of primary health care. Not only is this prohibitively expensive, but people often delay seeking medical care for relatively minor ailments until they have progressed into life-threatening emergencies. In one of the richest societies in the world, it is difficult to understand how an adult could not have access to necessary health care, but it is inexplicable when the victims are children. Attachment 3 illustrates this access issue.

C. Medical Liability Reform

Michigan has the dubious distinction of having the highest medical liability insurance premiums in the Unites States due to unconscionably high medical malpractice injury awards. This is good news for trial lawyers, but bad news for women seeking obstetric care. In rural Michigan, it is becoming commonplace for community after community to go without an obstetrician. Most rural hospitals see their primary missions as providing first rate emergency care and delivering babies. In the current health care climate, it is becoming increasingly difficult for rural hospitals to achieve either of these missions.

II. SUGGESTIONS FOR CONGRESSIONAL ACTION

We believe that community hospitals in small towns are a vital part of the U.S. health care system. With enlightened public policy, they can once again thrive. If left unattended, they will perish. We believe the following commonsense solutions will go a long way towards assuring the viability of rural community hospitals:

1. Adjust expenditure priorities within the Health Care Financing Administration such that Medicaid/Medicare reimbursement rates for rural hospitals cover costs and provide modest operating margins so as to assure the financial solvency of well-managed institutions.

2. Rather than focusing Congressional attention solely on providing health insurance for the uninsured, consider creation of competitive community block grants to encourage development of alternative approaches to health care delivery for the poor and near poor. It is sometimes overlooked that it is not health insurance that is needed by these people so much as it is health care they need.

3. Create incentives for physicians to provide care either free of charge or at substantially reduced rates for the poor and near poor. Congress should consider providing physicians with tax credits, and exempt from taxation income earned by physicians for care provided at substantially reduced rates.

4. Enact Federal medical liability reforms, especially in the areas of obstetrics and emergency care, that will preempt state laws and which will strike a fair balance between the interests of injured parties in reasonable compensation and the interests of society in assuring the availability of essential medical services.

III. CONCLUSION

Again, we thank the Subcommittee for inviting our participation in this hearing. We look forward to working with Members of the Subcommittee or their staff on public policy initiatives that may result from these hearings.

Attachment 2

Three Rivers Area Hospital Description
Three Rivers, Michigan

Three Rivers Area Hospital is a 60 bed general-acute hospital operated as a hospital authority under Michigan Public Act 47 of the Public Acts of 1945 since transfer from the City of Three Rivers in 1979. The Hospital experienced a severe financial crisis prior to the transfer and has since recovered financially, built and inhabited new physical plant in 1987 and has established financial viability. The success of the Hospital is directly attributable to the strength, courage and judgement of the Authority Board with Quorum Health Resources of Nashville Tennessee providing executive, financial and operations leadership since 1980.

Challenges to the Hospital include: financial losses on patient care, recruitment of healthcare professionals, ability to diversify into healthcare delivery and increased operating and insurance costs due to litigious patient attitudes.

During 1991, the Hospital successfully opened an eleven bed inpatient rehabilitation unit, a " distinct part" unit under the Medicare program. Outpatient services are extremely busy and have greatly exceeded the capacity established in the new facility designed in 1987.

Attachment 2

Conversion of diagnostic and therapeutic spaces to better serve outpatients will probably require construction well in excess of the Certificate of Need threshold, an unnecessary and onerous deterrent to effectively serve this shift in healthcare delivery.

Psychiatric inpatient care has been considered and granted a Certificate of Need with a $1.1 million conversion and construction cost; uncertainty of reimbursement led the Authority Board to decline establishing this needed service in Three Rivers, Michigan. Physician services are inaccessible to many patients in the Hospital service area. Specialties needed include: Pediatrics, Obstetrics/Gynecology, Orthopedics and Family Practice. New physicians have found successful practices here. But, physicians in training have no experience and develop no attraction to the broad clinical requirements of a rural practice; even though board certified specialists offer Specialty Clinics on the campus, young physicians are reticent to commit to practice in the rural setting.

Medical liability costs are astronomical compared to other states; for this reason, the Hospital is now providing financial assistance to physicians for medical liability insurance premiums related to practicing obstetrics and pediatrics.

Convoluted administrative processes in billing for patient care and meeting outdated Peer Review Organization patient care criteria further degrade the attractiveness of private practice for physicians. Physicians in solo private practice find a heavy burden in these administrative challenges. Group practice is generally not available in our rural areas, and such multi-physician group practices attract new physicians because of reduced time demands and simplified administrative concerns.

Three Rivers Area Hospital has succeeded in: recruiting and establishing needed physicians; cooperating with District Health Department in serving its population; improving outpatient services; diversifying inpatient care; moving forward in diagnostic, therapeutic and prevention services; and providing all healthcare services to the Medicaid patient financially possible.

YFC *The Youth and Family Cabinet of St. Joseph County*

"Helping minors and their families"

NOV 19 1991

RD [illegible]

November 15, 1991

TO:

Representative Glenn Oxender
Senator Paul Wartner
U.S. Representative Fred Upton
Governor John Engler
Representative Raymond Murphy
House Speaker Lewis Dodak

FROM:

Medical Staff, Sturgis Hospital
Medical Staff, Three Rivers Area Hospital
Youth & Family Cabinet of St. Joseph County:
  Department of Social Services
  District Health Department
  Community Mental Health Services
  Juvenile Court, Judge Thomas Shumaker
  Substance Abuse Council
  Intermediate School District
  Domestic Assault Shelter

RE: Health Care Access Crisis

Please review the attached Position Paper that summarizes the concerns of the above signatories to this memo, and contact the office of Mr. Larry Hermen, Executive Director, Community Mental Health Services of St. Joseph County at (616) 273-2000 regarding your attendance at a briefing for the media scheduled for Thursday, December 5, at 7:00 PM, in the conference room of the ISD building at 62445 Shimmel Road, Centreville. Our purpose is to alert those responsible parties to the ultimate financial and societal cost now being incurred due to the limitations, inequities, and barriers to treatment in the existing Medicaid reimbursement system, as it affects St. Joseph County children and families.

The briefing will be structured as a forum for testimony by health care providers and response by legislators to local concerns. Specific suggestions and solutions may be proposed that could lead to support of existing or creation of new legislation. Your leadership in this effort would be greatly appreciated.

cc: St. Joseph County Medical Society
    St. Joseph County Dental Society

Community Mental Health • Department of Social Services • District Health Department • Domestic Assault Shelter Coalition
St. Joseph County Intermediate School District • St. Joseph County Probate Court • Substance Abuse Council

Position Paper

HEALTH CARE ACCESS CRISIS IN ST. JOSEPH COUNTY

SUMMARY: Health care providers and public agencies in St. Joseph County, Michigan are alerting the State to the potential serious and long term impact on the basic health care of children and families from low income homes, directly due to the existing problems found with the State/Federal Medicaid payment system. Unless the State Legislature streamlines the current system, removes the economic disincentives found by physicians who wish to treat this diverse and needy population, and limits the liability found uniquely related to the practice of serving this population, the resulting loss of basic health care for thousands of citizens will cause an ultimate long term and permanent societal cost in dollars and productivity for future generations.

ST. JOSEPH COUNTY EXPERIENCES:

1. SERVICE COSTS. Few physicians are available to serve the Medicaid patient, without establishing strict rationing, quotas, or "acceptable fiscal loss limits" within their private practices. Those physicians who serve greater than 15% Medicaid cases in their practice run the risk of eventual financial ruin and potential cessation of their private practice. The recent reduction in the Medicaid office visit payment due to the State fiscal crisis has accelerated the shift of patients from physician based care to hospital emergency care. Hospitals in Three Rivers and Sturgis have begun to notice a sizeable increase in the Medicaid patient service demand, often for routine health care needs that, when delivered in a hospital setting, dramatically increase the ultimate cost to the State and taxpayers. Hospitals have begun to find themselves responsible for the large number of "Medicaid refugees" from the former private physician care system. Emergency Department care is, by nature, brief and episodic. If it becomes the only source of health care for Medicaid recipients, it will result in a less comprehensive, less preventative, and less consistent approach to health care than the traditional physician based office care. Ultimate costs to society may become enormous if this trend becomes "the system of care" for Medicaid paid outpatient services.

2. **BUREAUCRACY.** Physicians who continue to treat Medicaid clientele find that the paperwork/documentation burden alone is often enough to discourage further acceptance of new patients. The excessive use of State regulatory approaches to medical oversight and "quality assurance" may in fact discourage the very same practice of creative and personal quality health care that it attempts to guarantee. The likelihood of additional MPRO reviews that comes with the increased acceptance of Medicaid patients becomes a significant reason for hesitancy for many physicians who may wish to serve this population and contribute to the public good. One acute symptom of this dysfunction is found in the apparent arbitrary policy of the Medical Services bureaucracy to pend claims in times of uncertain state cash flow. The resulting costs for physician rebilling and receipt of late state payments are entirely born by each physician and never recovered.

3. **LIABILITY.** As fewer physicians accept new Medicaid patients, the burden remaining on those who do has increased. Staff physicians at both Three Rivers and Sturgis Community Hospitals have recently indicated their interest in sharing this burden through the development of a volunteer clinic approach providing gratis professional services, possibly sponsored by the District Health Department, or hospitals in each community. This potential solution, however, requires the State to extend its governmental immunity protection to these volunteers as it does with its own delivery of state provided health care services.

4. **PUBLIC POLICY LEADERSHIP.** All parties are disturbed over the lack of successful public policy aimed at preventing the social climate that may unintentionally encourage dependence on social welfare programs. Medicaid is routinely referred to as "the insurance program" for the poor, which it often becomes when jobs, training, and incentives for productivity are hard to find in many communities. We realize these are social problems that require both state and national leadership for resolution. Health care providers are now finding that increasingly higher numbers of heretofore middle income families are relying on the Medicaid system as their health care safety net. It is time that legislators address the need for new public policy that encourages and offers incentives to physicians to serve indigent patients rather than erecting additional barriers and obstacles.

SOLUTIONS PROPOSED:

1. Improve the standard reimbursement for Medicaid office procedures so as to encourage a greater sharing of the patient population among community physicians.

2. Streamline and reduce the required documentation and regulatory overkill that diverts valuable professional time from patient care.

3. Impose reasonable limits and access to large settlements and juried payments for noneconomic medical losses (pain and suffering) now commonplace in the medical malpractice arena. Provide mediation opportunities for health care practice disputes prior to litigation and court involvement.

4. Provide governmental immunity for physician services when provided in a local government or public agency operated health clinic.

9/3/91

Mr. Dingell. Thank you. Mr. McDonough, do you have any comments? The Chair will recognize my colleagues for questions. We will start with Mr. Upton.

Mr. Upton. Thank you. Obviously, one of our primary concerns is access to health care, particularly as we focus toward rural areas. As you see things in St. Joe County, Jim, and throughout our State, and I know there are a host of nightmares that have occurred in terms of providing quality service, but what percent of people that come for help do you think are either underinsured or totally uninsured that you provide health care for?

Mr. Foster. Twenty-five percent, as a generalization, seek primary physical care in our Emergency Department through the Urgent Care Program. Our visits last year, as I recall, less than 14,000 visits. Those people arrived, though, at a point of being very far into the disease process in many cases.

A patient comes in with an earache, an infant with an earache, and you discover pneumonia. So there is a lack of access across the range for a number of people. I have no way of knowing what the percentage is in our particular area.

Mr. Upton. I was delighted to hear in your statement regarding locating a physician from Wayne State to come to Three Rivers and, obviously, to fill the hole that is there, because I have talked to various hospital administrators throughout our part of the State.

I know, as an example, in Allegan County, when the obstetrician left, she was not replaced. They didn't advertise for someone to come in. In border counties, Berrien, St. Joe, Branch, I know there have been real shortages. Particularly as we look to Indiana and Ohio, the malpractice rates our physicians pay, sometimes tens of thousands of dollars higher than if they would move just a couple of miles south to the next State. I wonder if you might elaborate on those examples for our panel today.

Mr. Foster. We are very fortunate at Three Rivers to resident obstetricians-gynecologists, to join other family physicians. Babies are a booming business for us, part of that coming through the district health clinic, where three physicians provide prenatal care, as well as deliveries.

We have, as a hospital, entered into a relationship with those physicians providing obstetrical care, to assist them with excessive premiums in gaining, in buying professional liability insurance. It is something we felt that we needed to do in order to maintain the viability of their practices, and one of those physicians was looking at an assess of $50,000 to continue her practice in doing obstetrics and gynecology.

That is a very stiff premium payment to make when the physician is operating her own business. We have, in order to assure that service both to the district health department recipients and the whole range of clients in Three Rivers have gotten into that with that group of physicians.

The other conditions that we find is that—I know of a number of hospitals that physicians have left, and I think that is a significant part of the challenge that we have, is rural hospitals. It is not just the fact that the liability insurance, when you add a very heavy Medicaid population, in many of their practices the practice simply becomes financially inviable.

Mr. Upton. Dr. Smith, when he was here earlier, talked a little bit about the progress they have tried to make with regard to streamlining forms, reimbursement forms, paper requirements. As I said then, I have heard so many complaints as I traveled across the State. Have you been satisfied with the progress the State has made?

Mr. Foster. The physicians, as we all do, try to contain the overhead in their offices, and to receive a very small percentage of their charge for a given procedure or office visit; and to have to bill it numerous times in order to get it paid is not acceptable to them, one of the reasons that many of them have stated they ceased to offer services to new Medicaid patients. There is one physician on our medical staff at the present time who will accept new Medicaid patients. All of them will provide care for Medicaid patients who are presently in the practice, but those newcomers are not accepted in the practice. The billing procedures, and I think the peer review follow-ups, are a major part of that resistance.

Mr. Dingell. If the gentleman will yield, payments by Medicaid and the slowness of those payments also is a problem.

Mr. Foster. Exactly. We are presently at about $17, I think, having just come back from $14 for an office visit. When you add to that the slowness of having a cash flow and the perceived increase in the liability risk, medical liability of that clientele, then they have reasons that they restrict additions to their practice.

Mr. McDonough. Mr. Chairman, we heard earlier about 600-bed hospitals with 50 people involved in billing. We are a 60-bed hospital and we have about 15 people directly involved in billing.

Mr. Dingell. Your ratio is higher, but higher because you probably have a larger number of form filings to make relative to your number of patients, is that correct?

Mr. McDonough. And multiple filing until we get billed.

Mr. Dingell. Would you say generally the statement is that billings tend to be about as high as I indicated, or as high as you are indicating?

Mr. McDonough. Yes.

Mr. Dingell. I thank the gentleman.

Mr. Upton. One further question. I know my time has expired. I know that Three Rivers has, correctly so, I think, tried to focus more attention on outpatient services, preventive health care, thinking they can save money in the long run.

But because of the recent reduction in the Medicaid program in the State of Michigan, have you seen a greater shift perhaps towards emergency room than physician-based care? Has it been much harder to achieve?

Mr. Foster. Those patients are unable to achieve physician services at the present time in the office, and the only alternative then is to come to the emergency department, which generally our impression is that those people will resist that.

They will wait until very late in the disease process to seek care at the emergency department. I trust there is no restriction or hurdle for them to get over at my place. That certainly had better be true, but it is just much easier and much more desirable to have that physician relationship which they presently aren't able to get.

Mr. Upton. Thank you. I yield back the balance of my time.

Mr. Dingell. The Chair thanks the gentleman. The gentleman from Colorado, Mr. Schaefer.

Mr. Schaefer. Thank you, Mr. Chairman. I want to pick up on this form thing for one second. It came up earlier in a conversation. If indeed there is a small mistake on the form, it goes in, it comes back, OK, so we are talking here a period of a month, 6 weeks, or whatever, and not only are you delayed in getting the dollars, but also there is a possibility of breaking the law every time you make out one of these things and you don't do it right. Isn't this correct?

Mr. Foster. That is correct.

Mr. Schaefer. It seems to me one thing that has come out of this today, is the fact that we have to do our darnedest to simplify these forms, not only from that benefit, but because I do not want to continue to lose doctors that take care of these people.

You made a couple of statements here. We have problems in Colorado, in rural areas. How do you get physicians out there and how do you hold them? Is there a program in the State of Michigan at a reduced cost for tuition if a physician would agree to serve in a rural area for a 3- to 5-year period?

Mr. Foster. Yes. There is a Public Health Service program in which physicians have been able to—I am sorry, the term is work off, to have that forgiven over a period of service within our area, and for a number of years, our hospital benefited by physicians in the emergency department who were in that program.

A neighboring community, Dowagiac, has used a similar approach in having pediatricians at their hospitals. In one instance, of those physicians that have come to us, we succeeded in locating that physician in our community. He is a board-certified emergency physician, director of our medical—medical director of our emergency department, and the others have worked through their——

Mr. Schaefer. Obligation.

Mr. Foster. Yes, thank you. And then they have moved to other things. We work very closely with one of those in particular, and I think we were close in terms of offering her an attractive practice opportunity. She subsequently relocated with her husband, who had also been in that program, to Grand Rapids, and they live there now.

Mr. Schaefer. Also, you talk about the emergency room. In the State of Colorado, the number of people that go into the outpatient has just shot completely up. More and more people are going outpatient and trying to stay away from going into the hospital on a 2- or 3- or 4 day basis. That is true with you, right?

Mr. Foster. I would rather be at home than in the hospital.

Mr. Schaefer. I think that may be part of it, but the other part may be affording the cost of staying 2 or 3 days.

Mr. Foster. Yes.

Mr. Schaefer. Ms. McParland, you stated you know these budget cuts and you stated some cases that we would all dearly love not to have. From your experience, these are mostly the elderly, the poor, disabled or children?

Ms. McParland. Congressman Schaefer, I bring up the elderly and disabled particularly because the programs in place in the State of Michigan were created to provide assistance to the disabled who don't receive SSI or other Federal benefits. They were formerly receiving State-funded general assistance.

I guess I point those out by way of showing how deficient the so-called safety net is when it is not providing assistance to the very most vulnerable, those whom these programs were allegedly created to care for and they are not. There are many people somewhere in between who are also not receiving medical care or any form of cash assistance.

In my written statement that is now part of the record, I have a piece on there about what the so-called employables are. It is a group often overlooked because so much of the rhetoric involves cutting off welfare for the able-bodied single people.

Again, of course, in an ideal situation with a decent economy, those sorts of goals are laudatory. However, that is not the case in Michigan, and we have thousands and thousands of people who present vocational barriers, lack of transportation, there is no employment and training in this State anymore of any significance, who are not going to become employed.

I included some excerpts from a study of the State of Pennsylvania done by Professor Halter from the University of Illinois that was conducted in the 2 to 3 years following the termination or restriction of general relief in the State of Pennsylvania. And what it showed was it took the best group or the people who would be the most likely to find employment, and out of that group, only 10 percent—and this was with diligence in looking for employment—were able to find any employment of any duration in the following year to 2 years.

In this recessionary economy in Michigan, I think that gives us some clue as to what is going to happen. Obviously, that group of people who are not receiving cash assistance are also not receiving any medical care. The indigent medical care for people in this State who aren't on SDA or State family assistance, families with children, doesn't exist.

Maybe if you have a life-threatening condition and need a so-called life-sustaining medication, you will get it, and that is it. Obviously, Wayne County has the Wayne County Care System. It has some flaws, but compared to what is going on out of State, it is not that bad.

Mr. SCHAEFER. What about the immunization program for young children, for children under the age of 3? Has this been cut off, or is it continuing?

Ms. MCPARLAND. I am not aware of it being cut off or of any significant cutbacks. I believe that is pretty much a federally-funded program, on a match basis, I assume. I believe I would be aware if that had been cut back, and I don't think it has been.

However, some of the early prevention and screening detection systems for young children have been cut back in this State. Again, you have one thing working OK, but when you have basic programs slashed and cut, that obviously has to undermine the health and welfare of this population.

Mr. SCHAEFER. My other colleagues from Michigan may be more aware of that. That is one program I always strongly believed in. What about the workers? What will happen to them that were laid off like, say, at Willow Run?

Ms. McParland. I think what will happen to them eventually is what has happened to auto workers that were laid off and separated from employment over a decade ago. They spend a certain amount of time on unemployment compensation benefits. If they are lucky, they may be able to find other employment with equal or nearly equal pay.

If not, they would have, at least in the past, ended up on general assistance benefits to fill the gap, but those don't exist any longer. Unless these people are extremely disabled, which means they won't be finding employment eventually anyway, or otherwise qualified for other programs, there won't be anything for them.

Mr. Schaefer. You are saying if they don't find equal employment, they won't have health care.

Ms. McParland. Right. Obviously, they wouldn't have health care, either, and would be going to find the health care in some sort of government-funded system.

Mr. Schaefer. Has the private or volunteer sector stepped in on this in the past to help these type of individuals?

Ms. McParland. The private and charitable organizations in this State have done—taken heroic measures to fill the gap, but they cannot. There are too many people placing too many demands for too many different services in this State.

I will give you one example. Last April, this State stopped paying for delinquent water and sewage bills under its Emergency Assistance Program. Thousands, and I mean thousands, of people were facing imminent interruption of water service within the weeks following that policy change.

Our office filed a lawsuit in the Circuit Court and got a restraining order. However, in the 3 or 4 weeks that the policy was actually in place, the American Red Cross, located in Kalamazoo; the Society of St. Vincent de Paul, located in Lansing; and other parts of the State depleted their entire annual budgets on water bills for these people who were cut off assistance in 1 month.

Now, obviously, agencies like that, if they deplete their entire annual budget, the Red Cross had set up back in April something called an emergency triage system, or whatever, because they knew they would be inundated beginning in March, April and May with requests for emergency housing, water bills, utilities and other emergency medical needs, for example. Their budgets were gone.

It is, frankly, not something they wished to advertise as such an important health agency, but it is something that did occur, and that is part of the public record in our lawsuit.

Mr. Schaefer. Thank you, Ms. McParland.

Mr. Adamany, in your statement you stated that without urban medical care, health care for the poor and disadvantaged in our cities, the cities are going to basically collapse. You emphasize, this demonstrates no Federal or State health care safety net for the most needy exists.

How much longer can we go on? How much time do we have without people having basic services?

Mr. Adamany. About 2 years after we can no longer get voluntary Medicaid contributions. Probably survive as a financial entity for about 2 years at the rate of—at any rate of losses of $40 million a year we would begin to close our doors.

Mr. Dingell. Will the gentleman yield? Our committee submitted a report. That program, I am told, will terminate this fall, at the end of this year, because we were only able to procure a 1-year extension through calendar year 1992, at which time we are going to have to scratch around trying to figure out what we can do to preserve the program you and Mr. Schaefer are discussing.

Mr. Adamany. Mr. Chairman, the last year before we became eligible in Michigan for voluntary contributions, the losses in the Detroit Medical Center were $40 million. We probably couldn't sustain that for more than about 2 years, at best. In the past, we have had some opportunities to engage in cost shifting but, of course, there are more and more constraints on cost shifting, so it is very tough to figure out how you continue to keep the doors of the emergency rooms, clinics and hospitals open to all the people that come to you at a loss of $40 million a year. To give you a sense, the total volume in the Medical Center is about $960 million, so you deplete what little reserves you have very quickly.

Mr. Dingell. I apologize.

Mr. Schaefer. I appreciate the chairman's comments. How many people under the poverty level are shut out in Wayne County, approximately?

Mr. Adamany. Let's see.

Mr. Schaefer. I think I read somewhere it was like 350,000.

Mr. Adamany. Three hundred and fifty thousand is the number that do not fit into any eligibility categories.

Mr. Schaefer. What about the 43,000 that were incorporated into Mr. McNamara's county program? Is there in addition to? Are we talking 400,000, or are we looking at 300,000, approximately?

Mr. Adamany. I think the 350,000 in Wayne County are people who have no health care. I think that does not—that the 47,000 are not included in the 350,000 because they have county care, so they have some form of health care, no matter the character of it.

Mr. Schaefer. Mr. Chairman, I have no more questions. I want to thank the gentleman for giving us the opportunity to use his facility here. It has been very excellent.

Mr. Dingell. Dr. Adamany is always doing something like that. The gentleman from Michigan, Mr. Conyers.

Mr. Conyers. Thank you very much. You know, it is refreshing, Mr. Chairman, to hear about lawyers that are working in the public interest.

Michigan Legal Services, and Susan McParland in particular, have done yeoman's work across the years, and I was about to raise some discussion about how much free service is being dispensed, but I noticed in your brief-like testimony that was submitted that you say among other things, what alternatives exist to provide health care services and other services with public ramifications, that is, to provide food, drug abuse education and counseling, and then you list free assistance with court hearings.

Here it is providers at these clinics seek specialty care from area hospitals, universities, apparently with success. Attendance at these clinics is limited by geography and limited hours. That is encouraging, because my impression is, when you go to an emergency room in Detroit, you get emergency treatment. You are not given comprehensive, preventive treatment. I go into them often enough to see what is going on. You wait many hours.

I have had hospitals explain to me how they shrink their emergency room so that when EMS is looking for someplace to take somebody, they are filled up. They are filled up because they can only take six patients a night, so anything over six goes to Ford Hospital or down at the Center.

And I am happy to know that specialty care does come from hospitals. I had a very short-sighted view of this. To hear it from you is more reassuring than almost hearing it from anybody else.

Ms. McParland. Thank you. I might add, however, that these services, although more complex and wide-ranging than in emergency rooms, are extremely limited. These clinics—and there are only three of them throughout the State, are seeking this help and assistance from area hospitals and do, to some degree, receive them.

However, the numbers in the population that these people actually serve, it is small, obviously, just by virtue of the size and their extremely limited resources. I might add that since the State has dropped the Medicaid option of substance abuse treatment, and that is so limited, that is obviously putting a lot more stress on clinics like this out in urban areas that are trying to fill that gap, and they are obviously then not able to go on and do other things. Their resources are depleted in that area.

Mr. Conyers. Well, we turn now to Dr. Adamany, whose friendship goes back quite a way. He notified me that my niece had been admitted to the same law school that I attended; and my brother. My nephew sitting out here in the audience, Gregory Conyers, may also end up on the list trying to crash these doors one of these days.

But I am alarmed about the bleak picture that you have described financially, in terms of the hospital's existence. It sounds like the veterans' hospital that we have been working on to get built down there may be the only thing around when it is finished 5 years from now, at the rate this is going.

I am very concerned about that, but because you are not a physician and are on the board, it gives me great hope to enter into this discussion with you.

Much of this training is going on at the expense of the hospital and the surrounding community that trains all of these wonderful doctors, who are getting the greatest training on earth, and who immediately take this training and then split for the suburbs. They skip the rural areas, as Foster and McDonough can tell us in detail.

I have been in Minnesota with Representative Colin Peterson and my staff. These doctors get the heck out of the immediate city and city university that benefitted them. They become specialists to the third toe on the left foot, everything but what we exactly need; primary care, family medicine.

And we have this incredible disproportionate ratio of specialists at Bethesda Naval Hospital. I was told by the Chief of Surgery there that in his class, only he and one other student went into general medicine.

Well, the reasons for this are obvious. There is no money, and there is no status. We can't blame them in the kind of culture in which we are all a part.

But it would seem to me, in addition to giving the uncompensated care which we are all grateful for, that somewhere along the line somebody in the medical community ought to say, there ought to be more doctors going into the preventive family and basic primary medicines, which we don't have going on.

And it is extremely disturbing. We don't know how to get that placement. And I don't want to talk about it in terms of legislation, but I need people like you that are working with people and have some clout to see that we do this.

The number of minority physicians is still something that we are talking about. I see Charlie Vincent all the time—not recently since he became a political figure. I am not as close to him as I used to be. But the fact still remains that we have more doctors coming in from—and receiving training from other countries than we have minority physicians coming through our system. At the national level, we have 2 percent of the physicians in this country being African-American or other indigenous minority.

We have got to kick this up to, modestly, 6 percent to 12 percent, six times as much as we have now. It can't happen without enlightened people like you talking to some of these doctors for me so that we get this message through, and so it doesn't always just result in lawsuits and civil rights attacks and that sort of thing.

It seems that among reasonably dedicated people we could see this and deal with these two problems that I am referring to, and I think this should be a basis of your discussion before this committee.

Mr. ADAMANY. I appreciate your comments. You are right—I am not a physician, but I think I can probably tell that the Dean's blood pressure is probably going up behind me on this. But let me start at the end of your list of concerns.

We do have very substantial programs to recruit minority people into the physician-training programs now at the Wayne Medical School. In addition to those who are regularly admitted, we have a very fine program in which we admit students with high potential but not very good academic records and give them what is called a post-baccalaureate year, in effect giving them an additional year in preparing them for the M.D. program.

We have had a good degree of success in that, so the percentage of minority people in medical training has gone up. We are certainly above the national numbers, not the 2 percent you describe, but we are well above the 12 percent you describe nationally.

Similarly, we have addressed locally the concern about training more foreign physicians than U.S. physicians, both majority and minority races. We have—about 90 percent of our medical students are from within the State of Michigan, and almost all of the remaining 10 percent from outside the State are U.S. citizens. So that we also have moved a little bit on that. I wish we had solved all our problems as well as we are addressing these two, Mr. Chairman.

Now, the problem of practice in the city as opposed to specialization in the suburbs is an extremely complex issue. At a minimum, the entire incentive structure in medical care, the economic incentive structure, is in favor of specialization and in favor of suburban practice.

It is an interesting question, the extent to which we can expect solitary individuals to depart from powerful incentive systems created by the Nation's economic systems, including those mandated or supported by the Government. So that we really are asking individuals to be heroes, and, while there are some heroes, the likelihood there will be mass heroism is not high. So we have got to rethink the incentive structures.

The other factor is one that was previously mentioned, and that has to do with malpractice issues. I am going to let the Dean tell you what a terrible malpractice cost situation we have, but before I do that I am going to speak not from a physician's perspective but from a hospital perspective.

We had a lawsuit from a Medicaid patient who came into one of our hospitals, without adequate prenatal care, gave birth to a baby who by every morbidity factor should have died. The baby survived, but terribly, terribly handicapped. The physicians caring for the mother and the baby, in rushing that tiny bit of life to the intensive care unit, failed to take notes on every step that they did for a period of about 4 minutes. The jury verdict was $19 million against a hospital that provides 50 percent, more than 50 percent of the live births in the city, many of them to women with no prenatal care and drug and alcohol abusers.

We settled that case. I am not at liberty to say the amount we settled it for before we went to appeal, but I will tell you it was more than one of the recent deficits in the whole Detroit Medical Center.

Now, what is the lesson? We won't have such a lawsuit this year or next year or in the year following. The lesson is we are scared to death of malpractice lawsuits, and we will settle them in a profligate fashion to avoid a $19 million judgment. We are a $950 million a year corporation. No physician making any rational calculation will subject themselves to that level of risk. So I think that we have just an awful problem.

Mr. CONYERS. What do you recommend? This is what we are here for. Should we just cap it out at a few hundred thousand dollars, and end your problem?

Mr. ADAMANY. I think capping, because of its arbitrary character, not taking into account the severity of the injury, is rightly frowned on by those of us trained as lawyers. The other side is that there is nothing more arbitrary than the present system that becomes really a lottery. So we are going to have some amelioration of this, and it may be that capping will be a lesser evil than the one we have got, though it is still in the category of evils. It may be we will have to have a national insurance pool to address these problems.

Mr. CONYERS. What about revising the elements of liability? I mean, there is certainly something besides capping and a national insurance pool. In Canada, if I dare raise the question of our friends 3 miles away, the elements of liability are much different, and you have to prove a lot more, and you get socked with the attorneys' and courts' cost and sometimes a penalty if you lose the case.

And so it seems to me there are a wide range of legal considerations that would lead us to deal with this matter.

Now, in this horror story that you have volunteered, let me just ask you this. Were the lawyers at fault? Was the judge at fault? Was the jury out to lunch? Was the law bad? How do you assess this, since you have given us this bare-bones description of what is a horror story by anybody's definition? What happened? You mean the doctors were faultless?

Mr. ADAMANY. Well, the doctors may have been at fault.

Mr. CONYERS. The lady is nodding her head yes sitting behind you, and is apparently familiar with the case.

Mr. ADAMANY. Let's assume the doctors were at fault. Let's assume everybody in the system functioned flawlessly except the doctors. The fact is a $19 million settlement is far in excess of what is needed to support that youngster in a life that will not be a full life.

So that even making the assumption that the doctors were terrible, which is not the assumption we make because that is a hospital where the people come to us with no prenatal care, significant drug and alcohol abuse, and we have a wonderful mortality rate given the high morbidity rates we have got. It is a hospital with a superb track record. But let's give them that. We can still ask, what does a $19 million settlement mean? It means that we have gone well beyond taking care of that baby.

Mr. CONYERS. Well, I don't know that, sir. You give me a set of facts, you give me a conclusion, and then tell me, incidentally, that the child——

I am sorry. I see Chairman Dingell raise his gavel, and I think, as chairman of another committee, I understand what that means.

But at any rate, let's continue this discussion. It is not necessary that it be on the record. But it is important that I raise these concerns with you since this is in the local and national interest as well.

I thank you very much for your responses. Thank you, Mr. Chairman.

Mr. DINGELL. I thank the gentleman. The Chair also thanks the doctor for raising the question. I have some modest familiarity with this particular matter, too.

I would make one additional observation. The hospital in question may very well soon go broke in good part because of this, and it happens to be one of the very few places in Michigan where the poor, where the Medicaid-eligible mothers can have a safe and a decent pregnancy.

Ms. McParland, your comments were very interesting to me. I hear often from experts on health matters that, when people are without health insurance, they can and do get health care. They get it through emergency rooms, free clinics or something of that sort.

Now, in fact the evidence strongly suggests to the contrary, and studies recently conducted by UCLA indicate that people who don't have insurance and their children are about 30 percent less likely to see a doctor. What would you tell us your experience would lead you and us to believe?

Ms. McPARLAND. I am not familiar with that study. It is clear, however, that significant numbers of people in Michigan are not receiving health care at all and certainly not adequate health care. That is driven by the way the programs are structured. They cannot—I have given a fair amount of detail to the committee about the State medical care program.

I know Dr. Smith and Executive McNamara both pointed out that people who want and need health care badly enough will ultimately find it. That is our experience, and we represent classes of plaintiffs who are affected by the changes in the restrictions in medical care in this State. That shows us that that is just not true.

Firstly, to place that sort of burden on the elderly or disabled is, you know, ludicrous to begin with. And, second, it is just simply not there.

In the case of the Faircloths, who are named plaintiffs in the lawsuit we just filed yesterday, they—neither of them are able to get the test for their conditions that have been prescribed and that they desperately need. Neither of them are able regularly to get the prescriptions that they desperately need for their medical conditions. These are not anecdotal situations. But they are representative of what is happening to thousands of people.

Also, in this State, and I don't think I mentioned it earlier, and I know I heard when Dr. Smith testified he mentioned the Medicaid option services that Michigan had dropped in the past 2 years. They have also eliminated coverage for older QMB people, so elderly and disabled people who previously were receiving Medicaid are not, their incomes fall somewhere between $385 and $465 a month. They are no longer receiving any Medicaid coverage in this State. That option was dropped last year by Michigan. And about 17,000 people are affected by that reduction.

Mr. DINGELL. I would like your experience on another related matter. The same UCLA study found people without insurance who have chronic and serious illnesses are one-third to one-half less likely to seek care. Do you want to comment on that, even though you did not, in fact, see the study?

Ms. McPARLAND. Yes. I think that has a lot of validity. People who have chronic ailments tend not to be utilizing the system to the degree that people who are suffering from an acute ailment do. So that it is the emergency room service and payment that is burgeoning as opposed to regular kinds of office visits and so forth, which is pretty much backwards in terms of looking at efficient delivery of services.

People with chronic ailments, and we see it all the time among our clients, they learn to live with them. Somehow they incorporate this into their daily lives. Obviously, it takes its toll, and that sort of long-term deprivation will obviously result ultimately in more serious health problems, which the system ultimately pays for, of course.

Mr. DINGELL. The same study found that when without insurance people who even have serious symptoms such as loss of consciousness and bleeding are fully 50 percent less likely to seek care. Does that conform with your views?

Ms. McParland. It conforms with our experiences, yes, especially in the past 1½ years. I am aware of several people who have acute medical problems for which they are not receiving any help.

For example, one of our plaintiffs has a condition of uterine tumors that are so severe they cause her to hemorrhage almost on a daily basis. Because of the restrictions on hospital and surgical care in the State medical program, she has gone without the prescribed surgical procedures for 3 months.

She is not alone in that experience. There are many others like that that I am aware of. So, yes, I think that statement and conclusion is true.

Mr. Dingell. Thank you very much.

Mr. McDonough?

Mr. McDonough. Chairman Dingell, there was a recent study in the State of Michigan that might provide some of the information you are seeking. The Partnership for Michigan Health Care, which is a coalition of the Michigan Chamber of Commerce, New Detroit, several other members, did a poll last year, and in that poll they found that within Wayne County and western Michigan, about 40 percent, somewhere between 40 percent and 50 percent of people without health insurance will seek care when they need it from emergency rooms. Somewhere between 20 and 30 percent will go without care.

So you will see about 15 percent go to a free clinic when that is available, and they are available fairly often, and somewhere around that same amount will go to a family doctor. Of course, all people not on insurance aren't necessarily poor. Some people just don't have insurance. But it is a very high percentage of people, by their own measure, who say, when I am not well, I will go to the emergency room, or I will not get care at all.

Mr. Dingell. When they go into an emergency room, that means that the hospital has got to deal with them until they are well enough to return them to society.

Mr. McDonough. That is correct.

Mr. Dingell. If it is a serious disease or if it is a serious condition requiring surgery, you have got to give that and then you have either got to find somebody to pay the bill or you have got to eat the bill. And in the case of a 60-bed hospital, that could be a serious matter, could it not?

Mr. McDonough. It doesn't take more than one or two people to put us in a very bad shape.

Mr. Dingell. The interesting phenomenon I have seen in health insurance, in a lot of instances employers for a lot of reasons feel it desirable or absolutely necessary to move to a different carrier in which event they find that they might get a more agreeable rate. But they get coverage which does not include preexisting conditions.

So here you have got a guy who is working, covered by health insurance, his health insurance switches, and all of a sudden if he has, let's say, diabetes or cancer or something of this kind. Even though he has been working and doing his best to be a productive citizen, his condition is not covered by his carrier. Is that a common problem?

Mr. McDonough. That is quite common. We see the preexisting exclusion problem on a regular basis, when people are just left out in the cold. Beyond that, probably more so than in the urban setting, we see people, your typical family, mom, dad, two or three kids, between the parents working three, sometimes four jobs, at McDonald's or wherever to make ends meet, no, health insurance whatsoever.

I was in our emergency room with one of my children who had a broken arm. In walked a mom and dad, three kids with them, holding a baby, right next door. I couldn't help but overhear. They had no insurance. The baby had been coughing for about a week. Mom and dad hadn't slept for two nights, didn't have insurance, didn't have a doctor, didn't know what to do.

The mom said, I think the baby has infected fleabites. That was true. The baby also had pneumonia. We almost lost him. They didn't know what to do. They didn't know they could come in to see us. It was a tragedy. Fortunately, that child lived. I would imagine there are a lot more that don't make it.

Mr. Dingell. I agree, this is an important issue, but let's come back to the situation of preexisting conditions. They walk into a hospital, and you are stuck with the bill because the carrier simply will not pay the bill to cover preexisting conditions, is that right?

Mr. McDonough. That is correct. We are a community hospital. We have to provide the service.

Mr. Dingell. The same thing would happen to the doctor, would it not?

Mr. McDonough. Yes.

Mr. Dingell. If you were seeing this patient on an outpatient basis for that condition, all of a sudden you might find that condition was no longer covered, and he would not have eligibility for treatment under the policy, nor would you feel able to pay for continuing services, which you are under the law obligated to provide, isn't that so?

Mr. McDonough. We are legally obligated. We are also morally obliged. We don't turn anybody away.

Mr. Dingell. Well, Dr. Adamany, Ms. McParland, Mr. Foster, Mr. McDonough, we thank you for your invaluable assistance to the committee. We know you, Mr. Foster and Mr. McDonough, have come some distance, and we thank you for your valuable time.

The Chair announces the next panel will be composed of Dr. Suzanne Adelman, Past President, Michigan State Medical Society, and Mr. Richard Hiltz, representing the Michigan Hospital Association, President and Chief Executive Officer of Mercy Memorial Hospital, Monroe, Michigan. I am pleased to report that is in the 16th district.

Dr. Adelman, Mr. Hiltz, we thank you for being with us, and also your associate. We will recognize you for such statements as you choose to give us, starting with Dr. Adelman.

STATEMENTS OF SUSAN HERSHBERG ADELMAN, ON BEHALF OF MICHIGAN STATE MEDICAL SOCIETY; AND RICHARD S. HILTZ, PRESIDENT, MERCY MEMORIAL HOSPITAL, MONROE, MI., ON BEHALF OF MICHIGAN HOSPITAL ASSOCIATION, ACCOMPANIED BY CHARLES L. ELLSTEIN, GROUP VICE PRESIDENT, HEALTH DELIVERY AND FINANCE

Ms. ADELMAN. Thank you very much, Congressman Dingell, Mr. Chairman. We have submitted a statement which I would like incorporated into the record.

Mr. DINGELL. Without objection, your full statement will appear in the record, and we will recognize you for such statement you choose to make.

Ms. ADELMAN. Thank you. I would like to make some comments selected from that testimony, and also make some additional comments, if I may.

The problems we are facing in Medicaid, I think, have been discussed at some length today. The ones I heard being discussed are not the only problems, there are even more. I would like to bring up some additional problems, and also to suggest some directions that we would like to look to for the future.

Just to enlarge upon my own background, I am immediate past president of the Michigan Medical Society. I am a pediatric surgeon. I have an office down the street. I used to live next door to this building for 15 years, and my husband is a law professor that works across the mall from here.

I also practice at Children's Hospital of Michigan and Oakwood Hospital. My practice, including patients paid for directly by Medicaid and paid for by Medicaid HMO's, is approximately 60 percent Medicaid, so I am well aware of the problems we are discussing.

The problems we are primarily discussing today I think center around Access to Care and the cost of care. The AMA, looking at this problem, has attempted to come up with some suggestions, and I would like to enlarge upon just a few of the proposals in the AMA's Access to Care program.

The AMA Access to Care proposal does begin by asking for major Medicaid reform, specifically extending coverage to at least 100 percent of the poverty level. It also asks for addressing some of the disincentives for physicians to take care of patients on Medicaid by at least reimbursing at the same level of Medicare.

The particular care that Congressman Conyers pointed out of the difficulties of physicians working in the inner city are made considerably worse by the very high percentage of Medicaid patients, the very low compensation of Medicaid patients, is about 33 cents on the dollar, and the very high risk of liability suits, Wayne County being the fourth worst region in the country. It is an exceptionally unfavorable situation.

The other, if you like, pillar of the AMA proposal is requiring employer provision of health insurance. We are very well aware of the difficulties from small business and, in fact, small business and employees of small business are the key to some of the additional problems with Medicaid.

We have particularly the experience in Michigan of employees of small business, mom-and-pop stores, gas stations, et cetera, who find that their employers cannot or will not provide insurance, and for that reason, these people find that they need to use Medicaid as the insurer of last resort. There is a significant burden of Medicaid patients that comes from this source, people who are, in fact, employed and who have found ways of getting Medicaid to reimburse their care, and that is something that needs to be understood, and it is a direct result of the fact they don't have insurance supplied through their employer.

In order to make it possible for their employers to cover them, there are a variety of things that can be done, many of them are insurance reforms, purchasing pools, community rating. There are a number of things that are already out there and well-known and well-recognized; tax incentives, changes in the tax system.

For those who are simply uninsurable, we would like to see State level risk pools in all States. There are a variety of ways these can be subsidized. In fact, some States are already doing that for—I think it is for the uninsured, and that—otherwise uninsured, and in some States, in 11 States today, these are in existence and they are subsidized by State tax credits.

We do feel Medicare reform is necessary and have a list of proposals for that, and we also feel long-term care coverage needs to be taken out of Medicaid and separately financed.

As far as professional liability reform, there are quite a number of proposals that we have, most of them appear in either Nancy Johnson's bill or the Hatch bill, and I think if you look at the provisions of that bill, you will see the kernel of suggestions we would like to make.

In addition, there are other suggestions that have been made that are specific to Medicaid, and these include various ways of indemnifying physicians or protecting physicians from the full liability of taking care of Medicaid patients. While nobody wishes to deprive Medicaid patients of the right to sue, it would be a far different matter if the suit were directed against the State.

If, therefore, the physicians were employed under contract or were taking care of the patients in public health clinics under a contractual arrangement with the insurance provided by the clinic for that line of service, then that would mean the suit would be against the State. The State would soon become conscious of the level of financial exposure involved and would soon have additional understanding of the need to enact comprehensive professional liability reform.

The additional suggestions that have been made include ways to make insurance portable. The real pressure right now—one of the many real pressures for reform of the health care system comes from unemployment and the threat of unemployment, the threat of closure of the Willow Run factory and the threat to people who have otherwise been working and uncovered faced with losing their insurance.

If insurance were portable, this would be less of a concern. There are a variety of ways to try to make this portable. One is to prohibit pre-existing condition exemptions, to prohibit waiting periods, to make the insurance continue for a certain number of months after employment, and there are some additional ways which I have in my notes and I don't see them right now.

At any rate, there are a number of ways to prevent the new employer from excluding the patient from insurance and to make the insurance that came through the old employer continue on. There are other ways, of course, of setting up health insurance IRA's, which would be in themselves portable. If these were set up and financed, either through tax credits, through the employers, through vouchers—there are a whole variety of ways these could be set up, then the health insurance IRA would move with the patient or the beneficiary and would not be tied to the previous employer at all.

The problems in Michigan with Medicaid are similar to the problems in many other States. We have heard many of them. As an example of the extent of the problem, there are today only a handful of obstetricians and only a handful of pediatricians able to stay in practice—in private practice, and take Medicaid patients in the city of Detroit.

Again, Congressman Conyers has asked why that should be, and why people don't stay in the city, and I could point out people like, for instance, Dr. Herman Gray, who now works for the State for Medicaid, who was in practice down the hall from me as a pediatrician, one of the most respected pediatricians at Children's, very greatly beloved, and had to give up his practice. He had to support his family. He had to close his office and seek employment with the State. He just quit.

At the low point of the financial level of my practice, there is no question the reason my practice remained financed is because I am married to a law professor. Had I not had that cushion, I would not have been in practice anymore.

The administrative problems with Medicaid have been commented upon. I might point out, there is an additional wrinkle to the administrative problems of Medicaid that I can tell you about from experience. That is, we have payment on Medicaid patients, both from the State and also from the so-called Medicaid HMO's, and it is worth commenting on the difference.

The State, I will tell you, if you know how to tell Medicaid and you are experienced, the State pays reasonably soon. For people who aren't too familiar with it—our expectations aren't very high. We don't expect much in our office, but they do eventually pay.

However, the Medicaid HMO's have a far worse track record. They go on for significantly larger numbers of weeks, in many instances need a lot more telephone calls and requests for payment. We would be delighted if the HMO's would pay in 45 days. We also see the Medicaid HMO's imposing more red tape than regular Medicaid itself.

We see the need for more pre-authorization, more phone calls. We see more patients being directed to specialists of their choice, which may or may not be the ones that we would choose. We see skimming. We see patients who can be taken care of at a certain amount of profit, let's say, by the tertiary hospitals, sent to the cheapest possible hospitals, and only the most expensive patients being sent to the tertiary hospitals. They have no way of making up for their losses on the expensive cases.

As we look at directing more of our patients into managed care programs, we are talking about directing more of our patients, in many instances, into Medicaid HMO's, and we have more problems with Medicaid HMO's in terms of quality, in terms of billing, in terms of paperwork than we do in Medicaid.

One of the things that is a success, and I am very proud of having a part in starting it, is the Primary Sponsor Plan. It is about 10 years old. Looking at the control of health care costs in Wayne County, where it has started as a pilot project, the health care costs are 14.3 percent lower than in the fee-for-service patients.

The hospitalization is lower. It means more people are going to see a doctor, not the emergency room. There are 8 percent lower emergency room visits. This is, even though the patient population in the Primary Sponsor Plan have been selected—the people have been directed into that program as much as possible who have a greater need for health care than the fee-for-service population.

Again looking at it in terms of quality, has been very satisfactory also. The quality appears to be a bit higher in the Primary Sponsor Plan than in the fee-for-service program. The Primary Sponsor Plan is, in fact, a gatekeeper plan in which these patients are going primarily to private physicians who are being paid fee-for-service, but also a $3-per-patient-per-month capitation rate for case management and for being assured to be available for 24 hours a day.

Patients cannot go to the emergency room unless they have the OK of Primary Sponsor. Having overcome considerable legislature objection in many quarters, it is now being extended and will be offered throughout the State. It is similar to the program in Arizona which Congressman Dingell knows about and has incorporated in previous testimony.

In fact, when we were developing the Primary Sponsor Plan, we were in Arizona telling them about it, and they got theirs up and running before ours got started. The Arizona plan, as well as ours, are two of the successful ones in the country.

Missouri also has a successful plan of a similar nature. Monroe County, in Rochester, New York, my hometown, tried it, failed it. New Jersey tried it but it was voluntary and it failed. Minnesota tried it. They also had difficulties. Florida tried it and got into a lot of difficulties, low capitation rates, legal delays and a bunch of hassles.

These programs have not worked in every State where they have been tried, but the ones that did it the way we did, with good patient education, with good physician education and with good cooperation of the physician community and recipient community, have done well. The ones that have not done well are the ones that tried to be voluntary, had adverse selection and ran into State problems with rate-setting.

As far as voluntary programs, charitable programs, I also have considerable experience with that, having started a free clinic many years ago in the Jeffries project, which is still going and been incorporated into an HMO and have been involved.

We do have project HOW set up by Wayne Health. It goes to church parking lots and delivers primary care and has a tertiary care network of supporting people. Clearly, the problem with health on wheels, it is too small. Voluntary programs are never going to cover the waterfront. A combination of voluntary programs and community health care centers, particularly if you had professional liability care protection for the physicians, is reasonable and a viable consideration which I do recommend to you.

The sum of what I believe I am recommending would be Medicaid reform; be very mindful of the problems that you are asking for if you force patients into managed care programs such as Medicaid HMO's that we have in town. Certainly, some work better than others, but you do run into unexpected difficulties with those. The Primary Sponsor Plan is a model which is working extremely well, which we would commend to you.

We would ask for small business reforms which would allow small businesses to provide insurance for their employees with State risk pools to cover those who are unable to fit into the employer-provided insurance. Those are medically uninsurable, or employers simply can't insure them.

There are a variety of insurance reforms whose importance cannot be discounted. The importance of community rating can't be overemphasized. The importance of eliminating pre-existence and having coverage after someone loses employment. Those, in themselves, would make insurance almost completely portable.

Professional liability reform cannot be overemphasized. Physicians are afraid to practice in Wayne County. They are leaving Wayne County. It is because of professional liability, and it is because there is no way to cover the costs of professional liability with the high percentage of Medicaid patients.

I think we have gotten rid of the myth that Medicaid patients sue more. Nevertheless, they are being covered by Medicaid, which pays much less than any other insurance, so if you have to pay premiums of $60,000 or $80,000 a year, you have to get the money from someplace. Not everybody is married to a lawyer.

There is another—there is another thought which is a very interesting thought, and I will not try to take personal credit for that, and it comes from the Heritage Foundation, whose thinking you may or may not like, but it is a very fascinating concept, and that is of refundable tax credits and refundable deductibles, and that is covering, for instance, a variety of ways this can work, but you can have high deductibles on your insurance which can be paid for by the government by vouchers, prepaid.

If you have—this can work for poor just as it can for people who have private insurance. If you have a deductible—$5,000, you prepay it, poor people can't pay the money, obviously; you put the money into an account, it is prepaid. They then would pay for the services of lesser costs out of this sum of money, so it is there. They can pay for it.

They don't have to go around humiliating themselves. They can pay for it. But if they don't need all that money, then they get it back at the end of the year. So, they have an incentive to watch their payments and costs themselves.

They don't need a bunch—the health care plan doesn't need to pay a bunch of utilization nurses to watch the pocketbook. They would rather pay it themselves. If they need the care, they will then pay for it. It is a very interesting thought, regardless of the source, which I think takes some study and bears some consideration, and I recommend it to you.

I think it is important again to emphasize pulling the finance of long-term care and catastrophic care out of Medicaid. It doesn't belong there. It is overloading it. We have considerably more material, including recommendations and suggestions for cost containment.

The current thinking and the current effort on the part of organized medicine is strengthening the cost containment piece. There is quite a bit prepared we would like to share with you. It includes physicians sharing price information, insurance companies making coverage limits known; cost sharing, which has to be pre-funded, and a whole variety of other ideas. I think I will stop right now, and I will be very glad to answer questions. Thank you.

Mr. DINGELL. Doctor, thank you very much.

[The prepared statement and attachment of Ms. Adelman follow:]

Testimony

of the

Michigan State Medical Society

to the

Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives

Presented by

Susan Hershberg Adelman, MD

Re: Access to Health Care

February 27, 1992

Mr. Chairman and Members of the Committee:

My name is Susan Hershberg Adelman, MD. I am a pediatric surgeon practicing in Detroit and also am the Immediate Past President of the Michigan State Medical Society (MSMS). MSMS is pleased to have the opportunity to testify concerning the important issue of access to health care for Medicaid beneficiaries and the working poor.

My testimony is divided into three parts. In the first section, I discuss the views of MSMS concerning the issue of access to care in general. The second section focuses on the specific problems and concerns with the Michigan Medicaid program. The final section discusses the Physician Sponsor Plan, an innovative program that provides cost effective, quality care for Medicaid beneficiaries in Michigan.

GENERAL COMMENTS CONCERNING ACCESS TO CARE

Approximately 35 million Americans do not have either private or government-funded health insurance. A large majority of the uninsured, both in Michigan and throughout the country, are working Americans and their families. Most of the remaining uninsured are unemployed persons and their families who are below the federally established poverty level but are not covered by Medicaid.

MSMS strongly supports Health Access America, the AMA's proposal to provide universal access to affordable, quality health care for all Americans. I have included a summary of Health Access America with my testimony. Two of the key principles of Health Access America are reforming Medicaid to provide uniform adequate benefits to all persons below the poverty level and requiring all employers to provide adequate health insurance coverage for all full-time employees and their families. Both of these principles are discussed in detail below.

MEDICAID REFORM

A major problem with the Medicaid program is that only about 40% of Americans with incomes below the poverty level are covered by the program. Under Health Access America, new national requirements would be established to assure that all persons below the poverty level would be eligible for and receive a uniform set of adequate health benefits. The uniform benefit package would consist of those services currently required by

Medicaid plus prescription drugs, rehabilitative services, and emergency services. Each state should be permitted to cover additional benefits beyond the uniform benefit package at its own expense. Since the cost of covering all persons below the poverty level would be considerable, a phased in approach may be necessary.

Another significant problem with Medicaid is low reimbursement levels for physicians, hospitals and other providers. Inadequate reimbursement reduces access to care for Medicaid beneficiaries. In order to improve access, Health Access America provides that Medicaid reimbursement should be increased to at least Medicare levels.

A growing burden on state Medicaid programs is the cost of providing long-term care for the elderly as increasing numbers of senior citizens are forced to spend down their assets in order to qualify for Medicaid coverage. MSMS believes that private sector coverage for long-term care should be encouraged through tax incentives and an asset protection program with Medicaid coverage provided only for persons below the poverty level. Expansion of private sector coverage would reduce the pressure on state Medicaid programs. Expanding long-term care financing to the private sector is another key provision of Health Access America.

By mandating expansions to the Medicaid program, Congress has succeeded in increasing access to care for many low income persons. While MSMS supports expanding access to care, it is unfair for Congress to mandate states to provide coverage without providing adequate funding, particularly in these tough economic times.

MANDATORY EMPLOYER HEALTH COVERAGE

The second key element of Health Access America is to require all employers to provide all full-time employees and their families with health insurance coverage. Under this proposal, coverage would be made portable by eliminating exclusions for pre-existing conditions, decreasing waiting periods before coverage becomes effective, requiring community rating and mandating that employers offer an open enrollment period for employees who lose coverage under a spouse's health plan. In order to ease the burden on businesses, the requirement should be phased in over several years with only larger businesses being subject to the requirement initially. In addition, tax credits should be provided and risk pools created so that new and small businesses can afford the cost of providing health insurance coverage for their employees. The AMA is working to develop reasonable cost containment measures which would not negatively affect the quality of patient care.

PROBLEMS WITH THE MEDICAID PROGRAM IN MICHIGAN

MSMS strongly supports the goal of the Medicaid program - to provide health care for indigent women and children. However, because of the many serious problems with the Medicaid program in Michigan, this laudable goal is not being achieved. MSMS refers to this as "The False Health Care Promise of Medicaid."

I should first of all state that about 60% of my patients are Medicaid beneficiaries, so I am personally aware of many of the problems with the Medicaid program. These problems include unconscionably low reimbursement, cumbersome regulatory requirements and the extremely unfavorable medical liability climate in the state. These shortcomings have created serious access problems, particularly in the important area of primary care. For example, in Detroit only a handful of obstetricians and pediatricians in private practice still provide care for Medicaid patients.

Medicaid currently pays only abut 50% of what it is charged for physician services. As a result, the percentage of Michigan physicians who take care of Medicaid patients has decreased significantly over the past several years. We are pleased by the recent increase of 15% in Medicaid physician reimbursement that became effective on December 1, 1991. However, despite this increase, Medicaid physician reimbursement is still less than 70% of Medicare reimbursement and thus is not adequate to ensure access to care for Medicaid beneficiaries. We are also concerned that the 15% increase may be short lived. The increase was made possible only through a voluntary contribution program which may be prohibited after 1992. We urge Congress to pass legislation that would allow states to continue to use voluntary contributions to help fund Medicaid.

In addition to inadequate reimbursement, physicians who participate in the Medicaid program encounter cumbersome regulatory processes. Specifically, physicians billing Medicaid are often faced with rejections and significant delays in payment.

Finally, physicians in Michigan face an extremely hostile medical liability climate. According to the geographic practice cost index of the new Medicare resource based relative value scale, Southeastern Michigan has the fourth highest medical liability costs in the country. I have included with my testimony an article by Debbie Dingell that discusses how the medical liability problem in Michigan hurts access to care for Medicaid patients. I also have included a pamphlet on medical liability reform developed by MSMS, the Michigan Hospital Association and the Michigan Association of Osteopathic Physicians and Surgeons.

MSMS is also concerned regarding the elimination of Medicaid coverage for certain optional services in Michigan. We believe that Medicaid coverage for adult dental care, non-ambulance medical transportation and EPSDT outreach contracts should be restored.

PHYSICIAN SPONSOR PLAN

MSMS is encouraged, however, by the success of the Physician Sponsor Plan (PSP) in Michigan. The PSP program is a managed care plan that is the result of a cooperative effort between MSMS and the state Medicaid program. Under the PSP program, each patient selects a primary care physician who becomes the patient's physician sponsor. Physician sponsors agree to provide 24 hour a day access to care. The physician sponsor provides all primary care and determines whether the patient needs treatment from specialists. The physician sponsor receives a case management fee of three dollars per month for each enrolled recipient.

According to a recent evaluation, the PSP program has succeeded in reducing costs by over 10% while providing quality patient care. In our view, this program combines the best features of fee for service and managed care. Currently, the PSP program is available to Medicaid beneficiaries in Wayne County and in two other counties. However, over the next few years the program will be made available to all Medicaid beneficiaries throughout Michigan. MSMS believes that other states may be interested in adopting the PSP program and we will be happy to provide additional information concerning this program.

CONCLUSION

MSMS believes strongly that the AMA's Health Access America proposal would ensure that all Americans are provided access to quality, affordable health care. We look forward to working with you to ensure that the key principles of Health Access America are enacted as soon as possible.

I will be happy to answer any questions Members of the Committee may have.

Summary of AMA Proposal

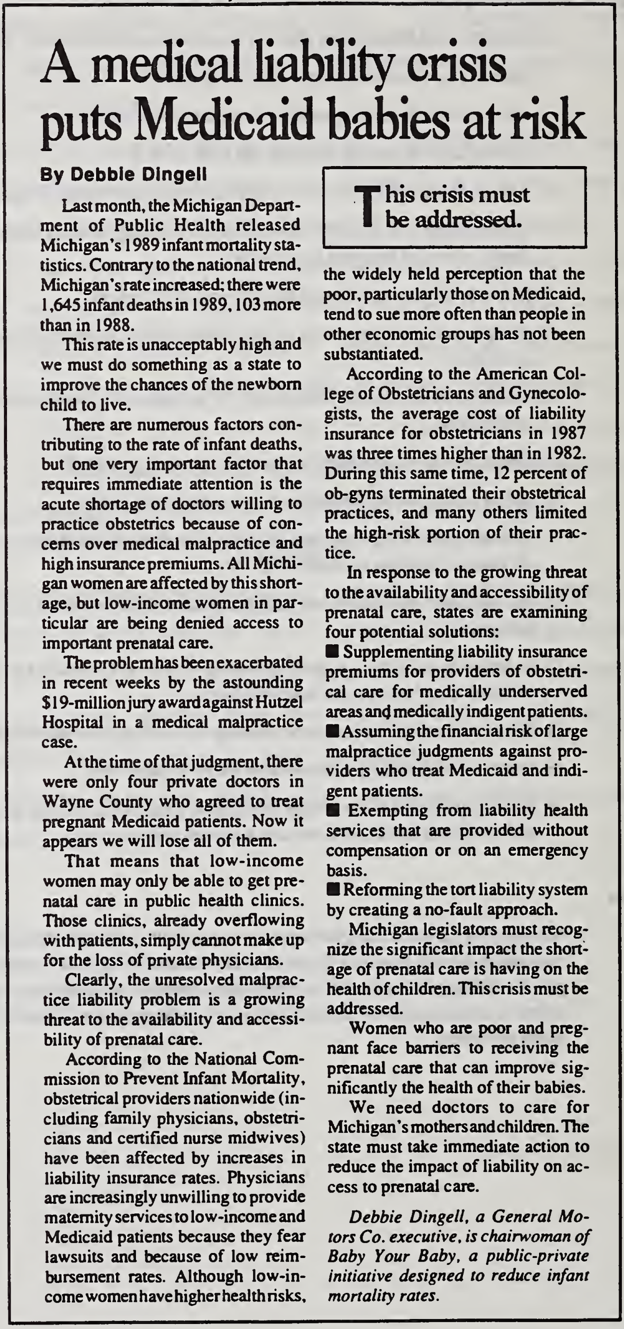
The elements of the AMA proposed plan may be summarized in the following 16 points:

1. Increase access by enacting major *Medicaid Reform.*
2. Increase access by requiring *employer provision of health insurance.*
3. Increase access by creating *state-level risk pools in all states.*
4. Maintain access and reduce costs for the elderly by enacting *Medicare Reform.*
5. Increase access and reduce costs for the elderly by enacting necessary legislation to *finance expanded long-term care coverage.*
6. Reduce health care costs through *professional liability reform.*
7. Maintain quality and reduce costs through *development of professional practice parameters.*
8. Reduce health care costs through *altering the tax treatment of employee health care benefits.*
9. Reduce costs by *encouraging cost-conscious decisions by patients.*
10. Reduce costs by seeking *innovation in insurance underwriting.*
11. Maintain quality through expanded *federal support for medical education, research and the National Institutes of Health (NIH).*
12. Maintain quality and reduce costs through *increased health promotion and disease prevention.*
13. Reduce costs and increase access by *amending ERISA or the federal tax code to equalize treatment of self-insured and insurance plans.*
14. Reduce costs and increase access by *repealing or overriding state-mandated benefit laws.*
15. Reduce costs by *reducing administrative costs and paperwork.*
16. Maintain quality and access through *encouraging physicians to practice in accordance with the highest ethical standards and to provide voluntary care.*

Conclusion

Accomplishing the goal of strengthening the American health care system through the elements contained in this AMA proposal will present an enormous challenge to all concerned. For its part, the AMA intends to move forward vigorously on legislative and other fronts. The AMA welcomes and encourages the support of others to help bring about an improved American health care system.

Detroit Free Press, January 14, 1991



A medical liability crisis puts Medicaid babies at risk

By Debbie Dingell

Last month, the Michigan Department of Public Health released Michigan's 1989 infant mortality statistics. Contrary to the national trend, Michigan's rate increased; there were 1,645 infant deaths in 1989, 103 more than in 1988.

This rate is unacceptably high and we must do something as a state to improve the chances of the newborn child to live.

There are numerous factors contributing to the rate of infant deaths, but one very important factor that requires immediate attention is the acute shortage of doctors willing to practice obstetrics because of concerns over medical malpractice and high insurance premiums. All Michigan women are affected by this shortage, but low-income women in particular are being denied access to important prenatal care.

The problem has been exacerbated in recent weeks by the astounding $19-million jury award against Hutzel Hospital in a medical malpractice case.

At the time of that judgment, there were only four private doctors in Wayne County who agreed to treat pregnant Medicaid patients. Now it appears we will lose all of them.

That means that low-income women may only be able to get prenatal care in public health clinics. Those clinics, already overflowing with patients, simply cannot make up for the loss of private physicians.

Clearly, the unresolved malpractice liability problem is a growing threat to the availability and accessibility of prenatal care.

According to the National Commission to Prevent Infant Mortality, obstetrical providers nationwide (including family physicians, obstetricians and certified nurse midwives) have been affected by increases in liability insurance rates. Physicians are increasingly unwilling to provide maternity services to low-income and Medicaid patients because they fear lawsuits and because of low reimbursement rates. Although low-income women have higher health risks, the widely held perception that the poor, particularly those on Medicaid, tend to sue more often than people in other economic groups has not been substantiated.

> **This crisis must be addressed.**

According to the American College of Obstetricians and Gynecologists, the average cost of liability insurance for obstetricians in 1987 was three times higher than in 1982. During this same time, 12 percent of ob-gyns terminated their obstetrical practices, and many others limited the high-risk portion of their practice.

In response to the growing threat to the availability and accessibility of prenatal care, states are examining four potential solutions:

- Supplementing liability insurance premiums for providers of obstetrical care for medically underserved areas and medically indigent patients.
- Assuming the financial risk of large malpractice judgments against providers who treat Medicaid and indigent patients.
- Exempting from liability health services that are provided without compensation or on an emergency basis.
- Reforming the tort liability system by creating a no-fault approach.

Michigan legislators must recognize the significant impact the shortage of prenatal care is having on the health of children. This crisis must be addressed.

Women who are poor and pregnant face barriers to receiving the prenatal care that can improve significantly the health of their babies.

We need doctors to care for Michigan's mothers and children. The state must take immediate action to reduce the impact of liability on access to prenatal care.

Debbie Dingell, a General Motors Co. executive, is chairwoman of Baby Your Baby, a public-private initiative designed to reduce infant mortality rates.

Mr. DINGELL. Mr. Hiltz and Mr. Ellstein, we welcome you. Mr. Hiltz, we recognize you.

STATEMENT OF RICHARD S. HILTZ

Mr. HILTZ. Chairman Dingell and members of the committee, thank you for being here today and allowing us to be here and talk with you. We appreciate your interest in the health care issues.

We have a written statement we have given you, and I would like to give you a brief summary.

Mr. DINGELL. Without objection, your full statement will appear in the record.

Mr. HILTZ. Thank you. The Michigan program long has been recognized as having one of the best Medicaid programs in the country, at least in terms of coverage and benefits.

Yet, while groups such as Public Citizen Research in Washington list Michigan as having one of the best Medicaid programs in the country, they noted that was less an endorsement of Michigan than an indictment of other States.

Michigan's program could have been described in the past as a mile wide, but an inch deep with broad eligibility and coverage, but limited access to many services because of the inadequate payment rates.

As a result of legal challenges, some of those rates have now been improved, but the State's fiscal situation, and competing societal demands, now place the benefit package and coverage at risk.

Last April, The New York Times summarized a report of the Physician Payment Review Commission, PPRC, which found that Michigan, at 62 percent, ranked 36th in the country in the percent of Medicare physician payment rates—even though that rate is not acceptable to many physicians—reimbursed by the State's Medicaid program. That low rate of payment, coupled with a nightmare of paperwork requirements and other road blocks to timely payment, have served to discourage private practice physicians from accepting new Medicare patients into their practices.

The end result is that, for many Medicaid recipients, the only available source of primary care is the hospital emergency room or outpatient departments. Yet, for most services, the basis for payment to the hospital is the same system of inadequate payment screens that cause physicians to refuse to participate. The hospitals' viability have been threatened by their willingness to care for Medicaid recipients.

The lack of reasonable payment standards and excessive bureaucratic practices, which require constant rebilling and follow-up to get pended claims finally paid, has resulted in limited accessibility to services for those covered under the program, let alone for those without any insurance.

The Health Care Financing Administration, HCFA, has not helped the situation, either, given its continued focus on whether the States are paying too much by exceeding the upper payment limit, while failing to develop standards to evaluate State plan amendments which reduce payment or impair access; both of these concerns are reflected in the Boren amendment.

The ability of Michigan hospitals to make voluntary contributions to the State in support of Medicaid during the last 2 years has been crucial to continuing the program. I would also add our thanks to all of you for your support on that difficult issue.

While the contributions have clearly resulted in an increase in Federal matching funds paid to the State, they have also allowed the State to restore or avoid cuts in benefits and eligibility.

The State has also been able to marginally improve physician and outpatient hospital payment rates. This will hopefully improve access to primary care services, and to make additional payments to hospitals with a disproportionate burden of indigent patients. How the State will fill this revenue gap after the contributing program ends is unknown at this time, but remains a major concern of the MHA.

Some suggestions for improvement:

From a Medicaid-only perspective, there are a number of suggestions we can make to improve the Medicaid program's ability to meet its objective of providing access to low-income people. Many of these proposals are likely to increase the cost of the program in the short term, but should result in savings over the long term, through improved health status and better care.

Extend the protection of the Boren amendment to clearly cover professional and outpatient hospital services. Mandate standards for HCFA to follow in evaluating States' plan amendments. Decouple Medicaid eligibility from other welfare programs. Establish fair national standards for eligibility and coverage.

Change rules to allow States to "lock in" eligibility for at least 6 months, without requiring a waiver, to facilitate enrolling Medicaid recipients in capitated, managed care programs. Address the medical liability problem at the Federal level, to reduce State-by-State variation in the cost of coverage.

Change the funding formula for Medicaid to make the formula more equitable. Simplify the data reporting requirements to make the system less costly to administer. Establish national standards for claims submission and prompt payment.

System reform: While we have made a number of recommendations to reform Medicaid, the best course of action for Congress to take is to reform the entire health care system, and to eliminate the need for a separate Medicaid and Medicare program. The MHA endorses the need for broad-based reform, including restructuring of the delivery system into Community Care Networks, which receive fixed per capita premiums to provide a basic set of benefits for all.

Such a plan would finally create consistent incentives for all providers to focus on efficiently delivered preventative care, rather than the current system of conflicting incentives, and the focus on restorative care.

We stand ready to work with you on meaningful reforms and appreciate the opportunity to express our views. Thank you.

[Testimony resumes on p. 311.]

[The prepared statement and attachments of Mr. Hiltz follow:]

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TESTIMONY OF RICHARD S. HILTZ

Thank you, Chairman Dingell and members of the Subcommittee, for the opportunity to appear before you today. I am Richard S. Hiltz, President of Mercy Memorial Hospital in Monroe, Michigan, and Chairman-Elect of the Michigan Hospital Association. With me today is Charles L. Ellstein, Group Vice-President for Health Delivery and Finance for the MHA. We appreciate the interest this Subcommittee has shown on the issue of health care in general, and the Medicaid program's ability to provide access to necessary care for low income people in this country. We are very familiar with Chairman Dingell's interest in health care, and look forward to the opportunity to work with him and the other members of the Subcommittee to effectuate necessary changes in our health care system to insure access to cost-effective, quality health care for all our citizens.

Michigan has long been recognized as having one of the "best" Medicaid programs in the country, at least in terms of coverage and benefits. Our state has taken advantage of most of the federal options for expanding eligibility to vulnerable groups, and Michigan's benefit package includes most, but not all, optional services. Yet, even while groups such as Public Citizen Research, in Washington D.C., list Michigan as having one of the ten best Medicaid programs in the country, they noted that was less an endorsement of the Michigan program than an indictment of the other states.

Michigan's program could have been described in the past as a mile wide, but an inch deep, with broad eligibility and coverage, but limited access to many services because of inadequate payment rates. As a result of legal challenges, some of those rates have now been improved, but the state's fiscal situation, and competing societal demands, now place the benefit package and coverage at risk.

PROBLEMS WITH THE MICHIGAN PROGRAM

Last April, the New York Times summarized a report of the Physician Payment Reform Commission (PPRC), which found that Michigan, at 62 percent, ranked 36th in the country in the percent of Medicare physician payment rates (even though that rate is not acceptable to many physicians) reimbursed by the state's Medicaid program. That low rate of payment. coupled with a nightmare of paperwork requirements and other roadblocks to timely payment, have served to discourage private practice physicians from accepting new Medicare patients into their practices.

The end result is that, for many Medicaid recipients, the only available source of primary care is the hospital emergency room or outpatient departments. Yet, for most services, the basis for payment to the hospital is the same system of inadequate payment screens that caused physicians to refuse to participate. Hospitals' viability have been threatened by their willingness to care for Medicaid recipients. The lack of reasonable payment standards and excessive bureaucratic practices, which require constant rebilling and follow-up to get pended claims finally paid, has resulted in limited accessibility to services for those covered under the program, let alone for those without any insurance.

Additionally, federal requirements and restrictions limit the ability of the state to work with providers to develop alternative approaches to providing care to Medicaid recipients. The federal waiver policy reflects the intention to allow innovative approaches while safeguarding the rights of recipients (but not necessarily providers - payment standards can and are waived by HCFA), but results in a sea of reports and inquiries that drain available resources from patient care to administrative needs.

The existence of a minimum payment standard for hospitals and other facility providers, however loosely defined and enforced it may be, has allowed the MHA and other provider groups to successfully pursue their right to reasonable payment for the services to which the standard applies. Unfortunately, the Boren Amendment does not cover professional services, and its applicability to hospital outpatient services is unresolved. Further, successful legal challenges to hospital and nursing home rates have increased the cost of the program to the state (and federal government). In the context of the current economic downturn, it is understandable, but no more acceptable, that the response of the state has been to cut benefits, eligibility, and provider payments wherever possible.

The Health Care Financing Administration (HCFA) has not helped the situation, either, given its continued focus on whether the states are paying too much by exceeding the upper payment limit, which exists only in regulation, not statute, while failing to develop standards to evaluate state plan amendments which reduce payment or impair access, both of which are concerns reflected in the Boren Amendment.

The ability of Michigan hospitals to make voluntary contributions to the state in support of Medicaid during the last two years has been crucial to continuing the program. I would also add our thanks to you, Mr. Dingell, and to Mr. Upton and other members of the Subcommittee, for your support on that difficult issue. While the contributions have clearly resulted in an increase in federal matching funds paid to the state, they have also allowed the state to restore or avoid cuts in benefits and eligibility. The state has also been able to marginally improve physician and outpatient hospital payment rates, which will hopefully improve access to primary care services, and to make additional payments to hospitals with a disproportionate burden of indigent patients. How the state will fill the revenue gap after the contribution program ends is unknown at this time, but remains a major concern of the MHA.

SUGGESTIONS FOR IMPROVEMENT

From a Medicaid only perspective, there are a number of suggestions we can make to improve the Medicaid program's ability to meet its objective of providing access to low income people. Many of these proposals are likely to increase the cost of the program in the short-term, but should result in savings over the long-term, through improved health status and better care.

- Extend the protection of the Boren Amendment to clearly cover professional and outpatient hospital services. Improved access to mainstream primary care has to result in better quality care for recipients.

- Mandate standards for HCFA to follow in evaluating states' plan amendments, to insure that states' assurances of meeting the Boren Amendment requirements are based on facts, not suppositions.
- De-couple Medicaid eligibility from other welfare programs. It is time to really make Medicaid the health program for poor people, not just for the "deserving" poor.
- Establish fair national standards for eligibility and coverage, to reduce the variability in the program across states.
- Change rules to allow states to "lock-in" eligibility for at least six months, without requiring a waiver, to facilitate enrolling Medicaid recipients in capitated, managed care programs. Current rules act as a barrier to capitated payment, since people without previous coverage will use more services initially after becoming eligible. This makes capitation a losing proposition without a chance to smooth the use of services over an extended period of eligibility.
- Address the medical liability problem at the federal level, to reduce state by state variation in the cost of coverage. Combined with more reasonable payment, this should improve access to primary care, and lower the cost of defensive medicine.
- Change the funding formula for Medicaid to make the formula more equitable. Consideration should be given to the federal government taking over funding, given the previous recommendations for uniform standards and expanded eligibility.
- Simplify the data reporting requirements to make the system less costly to administer.
- Establish national standards for claims submission and prompt payment. Providers should not have to wait for the next fiscal year for money to become available to pay claims.

SYSTEM REFORM

While we have made a number of recommendations to reform Medicaid, the best course of action for Congress to take, is to reform the entire health care system, and to eliminate the need for a separate Medicaid (and Medicare) program. The MHA endorses the need for broad-based reform, including restructuring of the delivery system into Community Care Networks, which receive fixed per capita premiums to provide a basic set of benefits for all. Such a plan would finally create consistent incentives for all providers to focus on efficiently delivered, preventative care, rather than the current system of conflicting incentives, and the current focus on restorative care.

Such reform needs to include reforms to small group insurance arrangements, and revisions to the tax treatment of premiums to achieve equity among employers of all sizes. However, the MHA believes that reforms must also mandate universal access, finally recognizing health care as a basic right for all residents, just as is education.

We stand ready to work with you on meaningful reforms, and appreciate the opportunity to express our views. We would be happy to answer any questions.

Thank you.

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President

FRIDAY FACTS

TO: Policy Staff

FROM: Jane Deane Clark JDC
Jill Kneisley JK
Nancy Struthers ns

DATE: June 21, 1991

SUBJECT: Medicaid Physician Reimbursement

Source: "Medicaid Reimbursement Policy", State Policy Reports, Vol. 9, No. 8, April 1991, pp.6-9

State Policy Reports recently reported Medicaid physician reimbursement payments, by state, for a doctor visit (for a recipient who has been seen by the doctor before). Amounts of reimbursement ranged from $45.00 in Alaska down to $10.00 in West Virginia. Most of the states fell within the $15.00 to $25.00 payment range (see Table 1, below).

Table 1 : Medicaid Reimbursement for Doctors Office Visit, 1989

Rank	State	Amount	Rank	State	Amount	Rank	State	Amount
1	Alaska	$45.00	18	New Mexico	$20.31	35	Delaware	$17.94
2	Massachusetts	41.00	19	Minnesota	20.00	36	Kentucky	17.77
3	Nevada	29.38	20	New Hampshire	20.00	37	Nebraska	17.70
4	Tennessee	27.00	21	Iowa	19.84	38	Oklahoma	17.50
5	Indiana	26.80	22	Utah	19.65	39	Missouri	17.00
6	Florida	25.00	23	Connecticut	19.50	40	Wisconsin	16.88
7	Georgia	25.00	24	Idaho	19.50	41	North Dakota	16.70
8	Kansas	25.00	25	Texas	19.50	42	Michigan	16.60
9	Arkansas	24.75	26	Virginia	19.00	43	Mississippi	15.00
10	Colorado	24.40	27	Ohio	18.91	44	Louisiana	14.28
11	Washington	22.62	28	Montana	18.84	45	New Jersey	14.00
12	Alabama	22.50	29	Oregon	18.81	46	Illinois	12.65
13	Hawaii	22.40	30	California	18.40	47	New York	11.00
14	North Carolina	21.88	31	Pennsylvania	18.00	48	West Virginia	10.00
15	Maine	21.25	32	Rhode Island	18.00	49	Arizona	n.a
16	Maryland	21.00	33	South Carolina	18.00	50	Wyoming	n.a
17	Vermont	21.00	34	South Dakota	18.00			

-Over-

The federal guideline for Medicaid payments, according to the report, is that reimbursement should be at a level that will allow enough providers to deliver covered services to Medicaid beneficiaries, to the extent that the services are available to the general public in the same geographic area. In practice, states generally set payments to providers, rather than agreeing upon prices with providers, which can limit the number of providers available that serve Medicaid patients. Geographic price levels and the fiscal condition of the state are among the factors assumed to influence the level of Medicaid payments set by states.

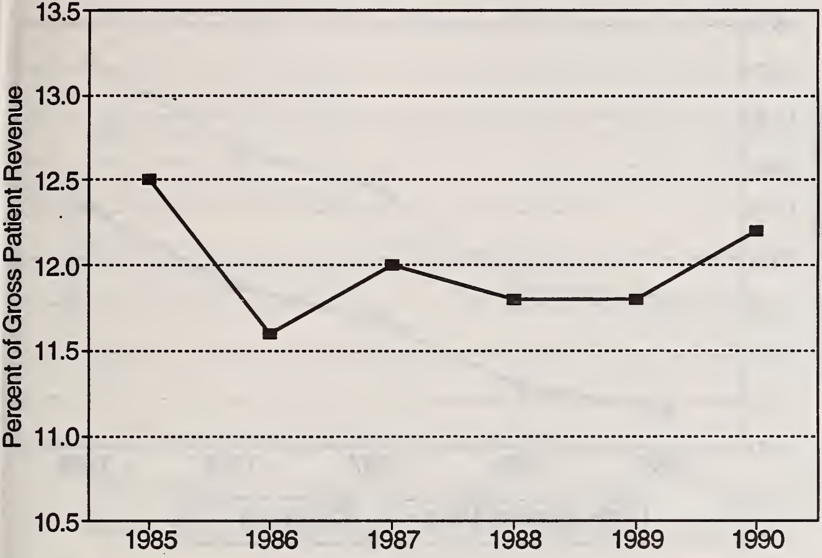
Another way of illustrating the variation in Medicaid physician payments by state is to present Medicaid reimbursement as a percentage of the Medicare reimbursement for the same service (Table 2, below). In most states, physicians receive lower payments for treating Medicaid patients than for treating Medicare patients. In New York, physicians who treat a Medicaid patient receive just 30 percent of the amount they would receive for treating a Medicare patient. Since low physician payments make it difficult for Medicaid recipients to find a doctor, many turn to emergency rooms or other expensive providers for treatment, or simply do not seek care. Raising Medicaid physician reimbursements to Medicare levels would cost about $1.3 billion.

Table 2: Medicaid Physician Reimbursement As Percent of Medicare

Rank	State	Percent	Rank	State	Percent	Rank	State	Percent
1	Arkansas	120%	18	Oklahoma	78%	35	Maine	62%
2	Georgia	112	19	Texas	77	36	Michigan	62
3	Alaska	106	20	Idaho	76	37	Ohio	60
4	Indiana	102	21	Wisconsin	76	38	Missouri	57
5	Nebraska	99	22	North Dakota	75	39	Connecticut	56
6	Massachusetts	94	23	Montana	74	40	Rhode Island	55
7	North Carolina	93	24	Virginia	73	41	California	54
8	Tennessee	92	25	Alabama	72	42	Maryland	51
9	Iowa	91	26	Florida	71	43	Pennsylvania	51
10	Utah	89	27	Vermont	71	44	Delaware	50
11	Minnesota	86	28	New Mexico	69	45	Illinois	48
12	South Dakota	85	29	Washington	69	46	New Jersey	40
13	Colorado	81	30	New Hampshire	67	47	West Virginia	35
14	South Carolina	81	31	Louisiana	66	48	New York	30
15	Hawaii	79	32	Mississippi	66	49	Arizona	n.a
16	Kansas	79	33	Oregon	66	50	Wyoming	n.a
17	Nevada	79	34	Kentucky	63			

Medicaid Percent of Gross Pt. Revenue

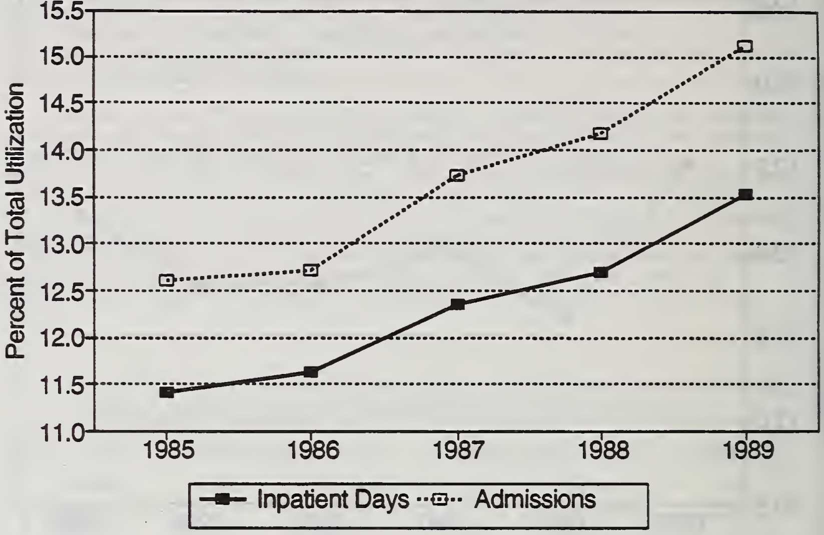
Michigan, 1985-1989



Source: American Hospital Association Annual Survey of Hospitals

Medicaid Inpatient Utilization Trends

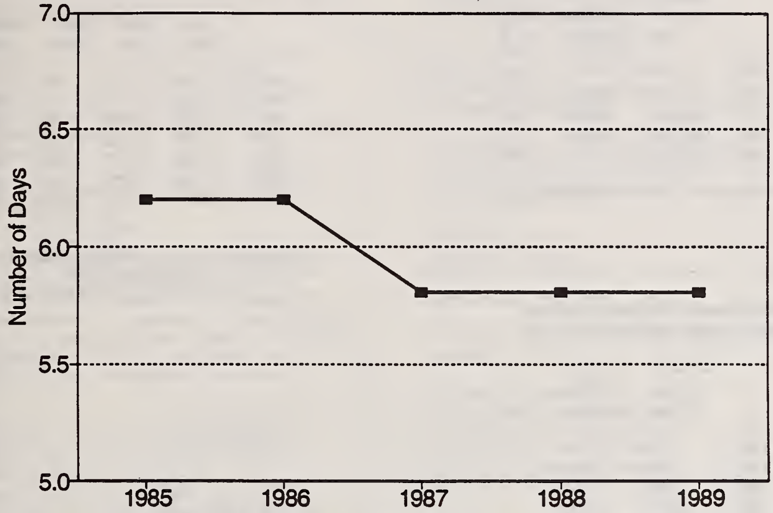
Michigan, 1985-1989



Source: Michigan Hospital Association Service Corporation Interactive Data System

Medicaid Average Length of Stay Trends

Michigan, 1985-1989



Source: Michigan Hospital Association Service Corporation Interactive Data System

Medicaid Inpatient Utilization Based on Expected Payer
Michigan Hospitals
Source: MHASC, Interactive Data System, 1987

	Medicaid Inpatient Days	Medicaid Admissions	Medicaid ALOS
1985			6.2
1986	968,576	156,555	6.2
1987	1,056,521	181,568	5.8
1988	1,063,899	183,445	5.8
1989	1,130,504	194,541	5.8

Normal newborns are included beginning 1987

Medicaid Percent of Utilization Measures
Source: MHASC, Interactive Data System

	M'Caid % of Total IP Days	M'Caid % of Total Admissions
1985	11.4%	12.6%
1986	11.6%	12.7%
1987	12.4%	13.7%
1988	12.7%	14.2%
1989	13.5%	15.1%

Normal newborns are included beginning 1987

Medicaid Percent of Total Gross Revenue
Michigan, 1980, 1985-1990

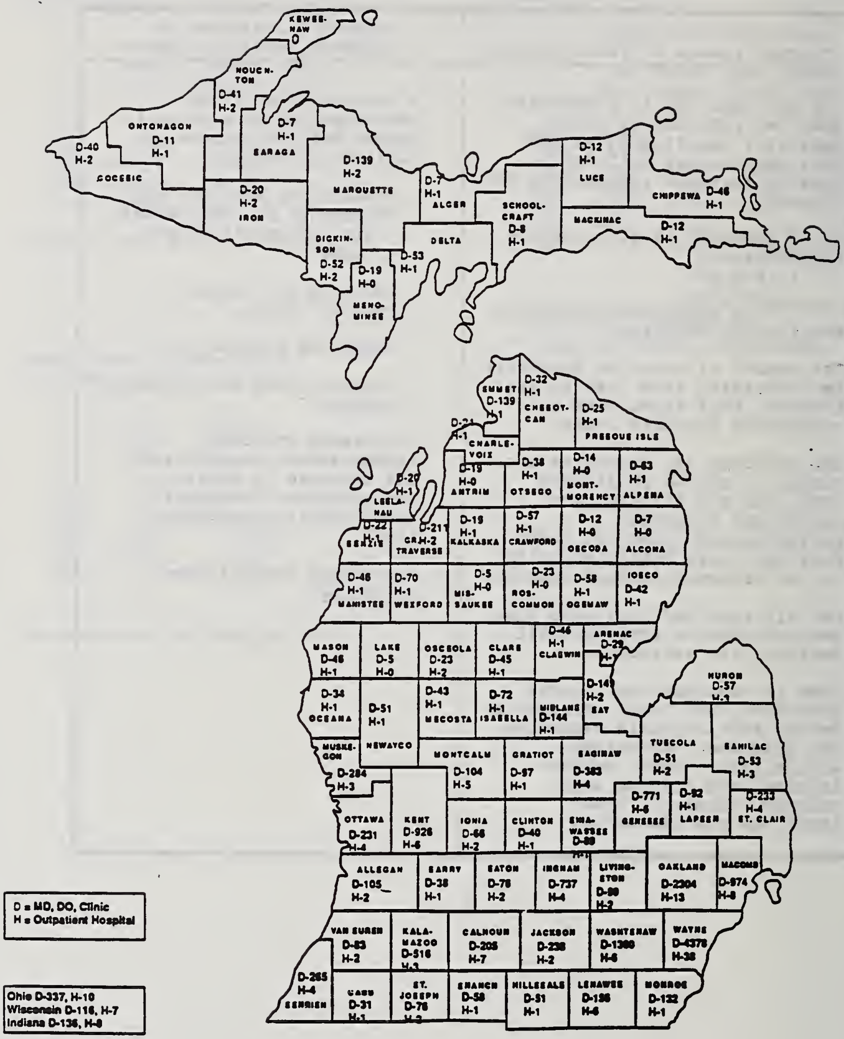
	Medicaid percent of gross revenue			
	All Hosps	Urban* Hosps	Rural** Hosps	Small*** Hosps
1980	11.3%	–	–	
1985	12.5%	–	–	14.1%
1986	11.6%	11.6%	11.4%	14.3%
1987	12.0%	12.0%	11.6%	14.5%
1988	11.8%	11.9%	11.2%	13.7%
1989	11.8%	11.8%	11.4%	14.3%
1990	12.2%	12.2%	11.7%	13.0%

* Hospitals that are in a metropolitan statistical area
** Hospitals in a nonmetropolitan area
*** Hospitals with <100 Beds, <4000 Admissions

PROVIDER PARTICIPATION/ACCESS

Current Levels of Participation	Ongoing Initiatives to Increase Participation
Any provider who is a Medicaid-enrolled provider is automatically enrolled as an SMP provider and may bill for covered services rendered to SMP clients. As of December 1991, there are approximately 12,900 MDs 2,700 DOs 150 outpatient hospitals enrolled in Medicaid. The number of enrolled providers is increasing from year to year, however, this alone does not constitute adequate access. The attached map indicates the number of active physicians (MDs, DOs and clinics) and outpatient hospitals participating (that is, these providers have submitted bills to the Program) in each county. Not all enrolled providers take new patients or actively bill Medicaid for services. Time is required for clients, providers, and local offices to become knowledgeable regarding new programs. Coverages, eligibility, county authorization, and billing were primary concerns. These inquiries are lessening.	- A continuing provider participation work group to pursue Medicaid access to services including: . researching provider hassle factors (e.g., unnecessary claim documentation and editing), . reducing the number of pending claims, . improving systems, and . creating more user-friendly manuals, - increasing provider reimbursement levels (e.g., 15% increase in physician and outpatient hospital fees effective December 1, 1991). - increasing managed care marketing.

Unduplicated Active Providers


KEWEENAW
0
HOUGHTON
D-41
H-2
ONTONAGON
D-11
H-1
D-40
H-2
GOGEBIC
D-7
H-1
BARAGA
D-139
H-2
MARQUETTE
D-20
H-2
IRON
DICKINSON
D-52
H-2
D-19
H-0
MENOMINEE
D-7
H-1
ALGER
D-53
H-1
DELTA
SCHOOLCRAFT
D-8
H-1
D-12
H-1
LUCE
MACKINAC
D-12
H-1
CHIPPEWA
D-46
H-1
EMMET
D-139
H-1
D-32
H-1
CHEBOYGAN
D-25
H-1
PRESQUE ISLE
D-21
H-1
CHARLEVOIX
D-20
H-1
LEELANAU
D-19
H-0
ANTRIM
D-38
H-1
OTSEGO
D-14
H-0
MONTMORENCY
D-63
H-1
ALPENA
D-22
H-1
BENZIE
D-211
GR.H-2
TRAVERSE
D-19
H-1
KALKASKA
D-57
H-1
CRAWFORD
D-12
H-0
OSCODA
D-7
H-0
ALCONA
D-46
H-1
MANISTEE
D-70
H-1
WEXFORD
D-5
H-0
MISSAUKEE
D-23
H-0
ROSCOMMON
D-58
H-1
OGEMAW
IOSCO
D-42
H-1
MASON
D-46
H-1
LAKE
D-5
H-0
OSCEOLA
D-23
H-2
CLARE
D-45
H-1
D-46
H-1
GLADWIN
ARENAC
D-29
H-1
D-34
H-1
OCEANA
D-51
H-1
NEWAYGO
D-43
H-1
MECOSTA
D-72
H-1
ISABELLA
MIDLAND
D-144
H-1
D-149
H-2
BAY
HURON
D-57
H-3
MUSKEGON
D-284
H-3
MONTCALM
D-104
H-5
GRATIOT
D-97
H-1
SAGINAW
D-383
H-4
TUSCOLA
D-51
H-2
SANILAC
D-53
H-3
OTTAWA
D-231
H-4
KENT
D-926
H-6
IONIA
D-66
H-2
CLINTON
D-40
H-1
SHIAWASSEE
D-80
H-1
D-771
H-6
GENESEE
D-92
H-1
LAPEER
D-233
H-4
ST. CLAIR
ALLEGAN
D-105
H-2
BARRY
D-38
H-1
EATON
D-76
H-2
INGHAM
D-737
H-4
LIVINGSTON
D-80
H-2
OAKLAND
D-2304
H-13
MACOMB
D-974
H-8
VAN BUREN
D-83
H-2
KALAMAZOO
D-516
H-3
CALHOUN
D-206
H-7
JACKSON
D-236
H-2
WASHTENAW
D-1360
H-6
WAYNE
D-4378
H-38
D-265
H-4
BERRIEN
CASS
D-31
H-1
ST. JOSEPH
D-76
H-2
BRANCH
D-58
H-1
HILLSDALE
D-51
H-1
LENAWEE
D-136
H-6
MONROE
D-132
H-1
D = MD, DO, Clinic
H = Outpatient Hospital
Ohio D-337, H-10
Wisconsin D-116, H-7
Indiana D-136, H-8

Mr. Dingell. Thank you. Mr. Ellstein, do you have any comments you would like to add?

Mr. Ellstein. No. I will be happy to answer any questions.

Mr. Dingell. We thank you all. The Chair recognizes the gentleman from Colorado.

Mr. Schaefer. Thank you, Mr. Chairman. This morning we have been talking about how can we improve the system of providing health care. We appreciate your statements.

As I stated before, I am afraid we are going to start losing more and more doctors if we don't start to reform that system. I think HCFA has gone overboard in a number of cases, in regards to the forms you have to file and the T's you have to cross.

I work closely with a hospital association in Colorado. Within the metro area we have about 12 hospitals. I have asked them many times, why does each individual hospital have to be an all-encompassing hospital that takes care of every problem?

When you start looking at the expense of the various types of equipment a facility must have—why do we not say, OK, if you have a cardiac problem, out of the 12, maybe there are 3 you should go to.

If you have another type of a problem, there is where you go, so each individual hospital could reduce its costs by not providing all essential elements to any person that comes in. Has this been something you have thought about, discussed within your hospital association in the State?

Mr. Hiltz. It is. I came from a hospital that merged a Lutheran hospital and Catholic hospital with a great deal of success. Would the Federal Trade Commission allow us to do that today?

Mr. Schaefer. I understand. It is not something we could not correct, if we should so desire, through legislation along this line. You know your business better than I do, but it just seems to me when you start talking about overhead costs and employee costs and everything else, if you could specialize in certain areas that everyone would know it would help. If I have this problem, this is where I go. If I have another problem, I go over here. You would still have a competitive situation within 3 or 4 of the hospitals that would do the same type of thing, so there would not be just one hospital you would have to go to.

It has just been something in the back of my head. What about the FTC? If we are looking at long-term reduction in costs, I think that part could be worked out. I just wanted to know if this is something that has been batted around.

I have talked to Larry Wall about this back in Colorado, and he brought up the same possible objection—not from his point, but from the FTC.

Mr. Hiltz. We have a new president of the American Hospital Association, Richard Davidson, and one of his messages is that hospitals have to collaborate and not compete.

This is a major issue for our State association. It is one we recognize is an industry problem. I think you are going to see the hospital industry focusing on this. But we also, as we have said, need your help in allowing us——

Mr. Schaefer. I fully can understand that, but you come and say, hey, look, this is what we have put together, we would like to do this to hold our costs down, and of course if you are the only hospital in Grand Junction, Colorado, that is a different story, but if you are in a metropolitan area, this seems to me——

Mr. Hiltz. You have got a good point. I think you are going to see much more focus.

Mr. Schaefer. Would managed care provide a solution to the problem of private physicians in Michigan not serving Medicaid patients?

Mr. Hiltz. Let me answer with an example, and maybe Mr. Ellstein can offer something more. Our local daily newspaper last week announced that two of our obstetricians are quitting delivering babies at the end of this month, end of March.

In 1980, we had 14 physicians deliver almost 1,600 babies. Last year we had six physicians deliver 900 babies. We know that at least 400 moms had to leave our county to get prenatal and OB care.

The tragedy is that these two physicians who are quitting carry a disproportionate share of Medicaid and poor moms. We expect that that number of 400 will go to 700, and these are the people who can't afford to have inadequate prenatal care. We have got to do something about medical liability in this country.

Mr. Ellstein. Managed care by itself is not going to do anything to provide care to the Medicaid population. If you combine it with reasonable payment levels and with changes to the legal environment within which health care is provided, then it should go a long way towards providing cost effective care to the Medicaid population.

One of the things I learned in my master's program course work is that one of the single best things you can do in order to improve the quality of care is to let all the providers providing care to an individual let each other know what they are doing.

Managed care provides a vehicle within which all the care can be coordinated, but by itself it is not going to solve the problem. We have to have more collaboration among all the providers in the health care delivery system.

Following up on your previous question, I might note it was exactly 1 month ago today, Mr. Dingell, that you and I had a lengthy discussion about the implications of antitrust in health care and the need to follow up on ways to allow more collaboration.

Subsequent to that conversation, I have had discussion with the people in the Washington office of the American Hospital Association and have urged them to move quickly to identify the specific barriers that antitrust and Federal Trade Commission present in allowing greater collaboration so we can work with the Congress to find ways to address those problems.

Mr. Adamany. To comment, if I may, on your question on managed care, the problem is pretty much of a dollars and cents problem. If the average obstetrician delivers 150 or so babies a year, and if the premiums in the City of Detroit are about $80,000 a year—I forgot the calculation, but you can do it while I am talking.

The calculation has been that if you take into account the general overhead, the general overhead of any physician's practice, except for some of the ones that have very, very high premiums, is about 50 percent, you figure 50 percent overhead—by and large, the physician with a high percentage of Medicaid patients paying these kinds of premiums loses money per delivery. You can't make it up on volume.

So what a managed care program does is simply spread these premiums so that the premiums are being paid on behalf of the high-risk specialists and the primary care people by the system, if it is a staff model system, so that the patients then get averaged out.

Also, the earnings of the high-risk people and the lower-paid people get averaged out. And with a little bit of luck, they might be able to make it financially. However, another way of doing it is readjusting the payment system. And remember, we haven't seen what will happen to the resource based relative value scale.

That is not just a Medicare phenomenon. That will be started in Medicaid in Michigan on April 1. There has been a specific decision made to allocate more money to cover obstetrical cases, a disproportionate amount of money not just going on to the RVRVS, but adding to because of the professional liability problems of OB/GYN, and with adjustments in the payment and with professional liability relief, you ought to be able to change that ratio to make it possible for private physicians to continue to take care of these patients, which I would submit would be optimal. I think there is room for both.

Mr. SCHAEFER. Doctor, earlier today I made the case that I had just been in and had a physical exam with my doctor. Of course when Members of Congress come in to their private physicians, you get an earful of the problems, and the doctor's wife is a nurse there. And she gave me the form that has to be filled out, created, I believe, by HCFA. They noted that if there is any kind of an error on it, it will take you forever to get it back, and you are in danger of committing a felony.

She showed me the list of the charges of what they can charge under the system versus what they would charge to me or somebody else who has their own insurance. It was drastically lower.

I have repeated many times, and I hate to keep repeating, but I am afraid we are going to continue to lose doctors to take care of Medicaid patients. She said we have some of our patients coming in, knowing the difference, wanting to pay in cash the difference, of course, which they cannot take.

They want this care. They want this doctor, but the doctor can't afford to do it. Now, that is a major problem that has to be rectified.

One other question, Mr. Chairman, how would the changes in the HCFA waiver process help the State to work to develop alternative approaches like Mr. McNamara's, in Wayne County?

Mr. HILTZ. I think if HCFA could give us some encouragement and incentives and flexibility, it would go a long way. With that, Charles, why don't you respond?

Mr. ELLSTEIN. The MHA has a task force on Medicaid reform that has been working with the State for a year now, trying to identify ways that we can change the delivery of the care of the Medicaid population to make it more cost effective and more efficient.

One of the things I have learned from talking to my friends in Medicaid, including Dr. Smith, is that even when the State has given a waiver to run a program in a particular county, every time it wants to expand that program to the next county, they have to apply for another waiver. That is ludicrous.

Mr. SCHAEFER. It is almost like every time a Medicaid patient comes to the doctor, they have to make over the form again.

Back in the middle 1980's, the State of Colorado's, legislature passed what I think is one of the best tort reforms in the States, when it comes to the ability for malpractice suits to exist. It put a cap on what you can go after.

I yield back, Mr. Chairman.

Mr. DINGELL. The time of the gentleman has expired.

Mr. Upton?

Mr. UPTON. Thank you, Mr. Chairman.

I appreciate the panel's testimony. More important, I appreciate your hard work in the past as well.

Mr. Hiltz, you indicated in your testimony that you wanted to reform the entire health system. I couldn't agree with you more. In my view, and I think many of my colleagues share this thought, we ought to blow up the whole system, blow it up, and start over, and put Humpty-Dumpty back together again, starting from square one.

The other day, I was curious to see how many health care bills have been introduced in the House. We have a program in our office computer that pulls this up—and it pulled up more than 1,200 bills. Then I typed in, Upton and health, and I had four pages, some 50 different bills that I have cosponsored, all involving some change with the system that we have.

As I look at a lot of the different health plans, Dr. Adelman—I appreciate your testimony with regard to health access, but as I look at the plans, none of them are perfect. There are good things and shortcomings as well in every plan.

One of the things I would like you to focus on this afternoon is the president's plan, which came out during our last recess, and didn't get a lot of favorable attention. But it had some things in there that I thought were important.

The vouchers, they are up to $3,750, that will take the savings up to the earner of $80,000 a year. It had some unspecified tort reform. Eliminated preexisting conditions after 6 months.

I can tell you, I know so many small business people who want to provide health insurance to their employees, who may have some preexisting condition, and they are out in the cold in terms of what may happen to them.

We talked a little bit earlier about deductibility for small businesses, how they are discriminated against because they only get 25 percent off rather than 100 percent. Medical IRA's, you talked a little bit about that. Someone in my office talked about that. I support that, pooling businesses together to look into the savings costs.

Obviously, I focused some of my questions, with the previous panel, on administrative costs which are a real nightmare. In terms of dollars to the patient, a real mess.

What are some of your thoughts regarding specifics of the administration plan? What elements do you like from what you have seen, what don't you like?

Mr. ADAMANY. I think the tax credits are——

Mr. UPTON. It is actually a voucher, it is not a credit.

Mr. ADAMANY. It may have many of the characteristics of a credit. You think this is probably a good idea. The amount of money, however, being proposed does not look adequate.

When we look at the cost of health insurance per person or per family, this just doesn't look like it would touch it. So if it were for a more adequate amount of money, I think it would function in an entirely different way from the way it would function now.

In the AMA's health access project, we talk about a basic benefit package. If you cost out the basic benefit package, I am not sure the amounts of money being proposed by the President would even cover a basic benefit package. If the vouchers were for more so that there were discretionary amounts of money, as we talked about earlier, that would be in a health IRA, that would allow the patient to make economic decisions with the incentive of having some money that might come back to them at the end of the year, then it might work in a way which would actually help to keep down health care costs.

I was recently in Australia, and in Australia it is very interesting what they do. They simply deduct I think it is $150 every 2 weeks from payroll, and they just give that. That is the money that has to be paid for health care. They pay that to the government for health care of the everybody who is not employed or is on welfare. Their welfare is quite generous, and they deduct $150 a week from the welfare payment, and that goes to medical care.

What the Australians told me is, you get Medicaid for that, but if you have my money, you have to pay private insurance on top. That is the way their system works. It is simple, logical, but obviously it is not a one-tiered system, which is what many of us have tried to say is our objective. And I don't know if it is realistic or not, but I think the problem—probably the big objection to the president's proposal is not necessarily the ideas in the proposal, but it probably doesn't go far enough.

Obviously, we all know that the financing is floating around. But the amount of money that he is asking the tax credits or vouchers to cover just don't look adequate.

Mr. UPTON. So that would be the biggest shortfall that you see?

Mr. ADAMANY. Yes.

Mr. UPTON. Do you like the other elements?

Mr. ADAMANY. There is a lot that is good in it. Yes, I think that the professional liability part is good. I don't think we have a lot of other specific objections, except that it doesn't go far enough in developing that financing problem, it doesn't go far enough at all in discussing where the money could come from.

I really think I have got to discuss where the money would come from. In the various European health care systems, these are usually payroll taxes. Now, payroll taxes don't have to necessarily finance a one-payer system like the Canadian health care system. You can do a lot of things with payroll taxes.

The advantage of payroll taxes is they spread the base of financing as widely as possible, they spread it like Social Security does. You can take the payroll taxes and put them in IRA's if you want to, or you can have them go to support whatever you want. Senator Kerrey's bill has something which looks like State sickness funds, which looks like the German sickness fund. The Germans have different financing for both systems.

Payroll taxes may turn out to be one of the equitable forms of financing. But you have got to answer that question, and I believe that you have got to sooner or later give up the fantasy that you are going to cover the costs by eliminating all fraud and eliminating administrative waste and you are going to magically cover everything, because I just don't think that you are going to get that much more efficiency when you federalize something.

Mr. SCHAEFER. Doctor, what about value-added tax?

Mr. ADAMANY. Well, you know, economically, the objection to a VAT is that it is harder on the poor. The burden falls on the poor. That is why people tend to have problems with it.

Where you need VAT's is where you don't have the ability to collect income taxes. One of the advantages to taking the money out of the income is that you cause everybody to report their income. For instance, if you put the tax on the income and then they appear and say they are uninsured, they appear at the emergency room, they say they don't have any insurance, we say, why, it turns out they didn't file any income tax. And you probably could flush out a good deal of the underground economy that way and finance part of your health care system.

Mr. UPTON. Not all.

Mr. ADAMANY. Not all.

Mr. SCHAEFER. You could flush it out of the VAT tax, too, because they buy a lot of things.

Mr. HILTZ. While we are talking about the specifics of the President's plan, I would like to offer a personal view of the process. You challenge us, the industry, to come back with ideas and proposals and suggestions. Maybe I am naive, but I have been really impressed with the State of Oregon and the fact that they have got providers, employers to talk about meaningful reform to improve the system.

They had to make a couple of attempts at it, but they finally took it to their people in meetings, and the people, after modification, endorsed it and said, yes, we would even be willing to pay more taxes if we thought the system was meaningful and we got value for our money.

Don't shoot at them for the process. Help them make it better, and maybe let them try it. I have not seen anybody take as broad an approach in trying to reform a system in health care as they have. And I think they have been conscientious about it. Maybe there are flaws, but, boy, they have done a super job at trying to get everybody involved.

Mr. UPTON. I appreciate your comments. One of the things where I think there is a shortcoming in the administration plan is with lack of catastrophic coverage. I can say for myself, when I voted for catastrophic health, I also voted to repeal it a couple of years later, and there were a bunch of nay-sayers across this land, as I would go back to our district and elsewhere, who flooded the rooms, the town meeting halls, my mail. I have had more mail to repeal that than any issue still, 6 years later. The count was about 2,000 in favor to 5 against. Less than five people asked that that program stay.

And what happened was, all these different supposed—I should say "all"—some supposed interest groups were out there who scared the willies out of our constituents. And unfortunately, later on, we tried to make it voluntary so that people could sharpen their own pencil, and calculate how it would impact their own household, sit down and try to figure that out, and they would allow them to opt out one time, and never opt back in, to try and keep that program there. But we were unable to make that plan on the Floor.

Many of us voted for it, and it passed overwhelmingly that year. Two years later, it passed overwhelmingly again to repeal it. One of the reasons why I think this committee is taking time, careful time, is because we want to make sure we have the opinions of groups like yours, as we blow up this system and put it back together.

I appreciate your testimony and I look forward to working with you down the road.

Mr. Hiltz. On catastrophic coverage, our population is getting older. We are keeping people alive longer. At some point in time, we are going to have to access long-term care.

Mr. Upton. Thank you, Mr. Chairman.

Mr. Dingell. The Chair thanks the gentleman.

The gentleman from Michigan, Mr. Conyers.

Mr. Conyers. Mr. Chairman, I have listened to the testimony with great interest, and I commend the witnesses. I don't have any questions at this time.

Mr. Dingell. The Chair thanks the gentleman.

Mr. Hiltz and Mr. Ellstein, I remember discussions earlier here, particularly on the subject of antitrust. I would like to come around again to a matter which I think was touched on in our earlier discussions—voluntary contributions. I gather you are a strong supporter of that?

Mr. Hiltz. Absolutely.

Mr. Dingell. Not because of the strong merit of that particular proposal, but simply because it makes the government pay a fair percentage of the hospitalization costs; is that correct?

Mr. Hiltz. Our State is in difficulty, as you are well aware. This is one method we can help participate to help the State improve benefits and cover more costs.

Mr. Dingell. Dr. Adelman, do you have the same feeling?

Mr. Adamany. Unless you can come up with a better idea. But if you can't come up with a better idea, we would die without it.

Mr. Ellstein. If I could put a different cast on it, the MHA has always opposed the idea of asking providers to pay for Medicaid. In this State, in this economy, the alternative is so much worse that we had no choice.

Mr. Dingell. I think the whole idea is basically a sorry one, but it was done by the States because they had no alternative. And it was supported by the professions and by the hospital people, simply because there was no accessible alternative. It was either that or see the government shirk its responsibility for Medicaid.

Mr. UPTON. If I may ask the gentleman, I might remind you as well that it was the Reagan administration who came up with the idea to get away from raising taxes.

Mr. DINGELL. It didn't take long for them to repudiate it, but the gentleman is correct. I am not critical of the Reagan administration at this particular point. I would simply use this as a prefatory statement to indicate that at the end of this year, the voluntary contribution system is going to terminate. And the people sitting up here did the best they could to get this extended over the rather vigorous objections of the administration.

Can you give me some examples of the services and benefits the contributions have helped bring about? What would have been terminated had we not had the voluntary program?

Mr. ELLSTEIN. I think the first direct program that was saved was the Medicaid program itself. There was talk a year ago about the State of Michigan terminating its Medicaid program because there just wasn't going to be enough money to fund it through the end of the fiscal year. So there was serious discussion about whether we were going to have to terminate the Medicaid program part way through the year.

The existence of the voluntary contribution program allowed enough money to come into the program that some hospitals with disproportionate Medicaid loads helped out with some additional payments. The program was kept in place. The State was able to restore a 20 percent reduction in physician payment rates, which was implemented last April 1st. That was restored partially through the voluntary contribution program.

We have been able to increase physician and outpatient hospital payments by about 15 percent, as of last December 1st, hopefully to encourage more physicians to treat Medicaid patients and to reduce the losses that hospitals incur in filling the gap.

We were able to avoid the elimination of several of the optional coverages, and I think that you could also indicate that the proposal to restore adult dental coverage is probably this year at least partially due to the existence of 1 more year of the voluntary contribution program.

There is no doubt in my mind that the Medicaid population is receiving significantly more service because of the contribution plan than they would have otherwise. I am frightened to death of what happens when the plan ends. We are going to be able to repeat our plan one more time in the fall of this year for fiscal year 1993, and after that, I don't know what is going to happen. The conditions under which provider taxes are allowed will make it very difficult to put through those kinds of taxes, which are really taxing providers and people who are getting health care to pay for Medicaid rather than spreading the burden equitably among all citizens.

I am very concerned about what we are going to do to fill the gap, unless we see a very significant improvement in the economy far beyond anything that Michigan has ever experienced before.

Mr. DINGELL. I have a curiosity as to what happens to these programs if this program expires. What then transpires? Do these programs terminate?

I am sorry, Dr. Adamany, I should ask you that.

Mr. ADAMANY. Let me just make one comment. I think the hospital association can probably give you a broader ranging comment, but to jump in with one point on the physicians side, the 15 percent increase in the physician payment should be looked at with a little bit of sophistication, because what actually happens, two things at the same time. One is, 15 percent more money was put into the physician line of payment as a result of the voluntary program. And the Medicaid program also adopted the RVRVS.

The RVRVS, as you know, shifts incentives by paying relatively more for primary care in order to shift physicians into primary care and paying relatively less for tertiary services. There was also a specific decision made to allocate a fixed amount of additional money to try to bring OB/GYN payments up to speed.

Now, moving on to the RVRVS meant tremendous allocations in the previous payment in what was previously paid, for Medicaid just as it did for Medicare. You all know the difficulties that surgeons are finding with the RVRVS, because the surgeons are the losers and the primary care people are the winners.

Going in Michigan to the RVRVS, with the amount of money available to pay physicians, meant that a decision had to be made, obviously there was no way that they could pay at the level of Medicare, so the decision was initially made to pay at the level of 70 percent of Medicare, but pay on the RVRVS.

Now, when we took our first look at that, that meant that we were going to in many instances have lower payments for Medicaid after the 15 percent increase, than we had before. Now, physicians were being paid somewhere in the range of the 30 percent of charges by Medicaid. I was just told by an orthopedic surgeon that they are actually being paid between 1 and 30 percent of charges.

Ms. ADELMAN. I think for pediatric surgeons it was probably mid-30—about 33, 35 percent of charges or thereabouts. Payments for all of my procedures were going to go down with this 15 percent increase. Now, we immediately saw that this was going to really deprive patients of access to a great deal of tertiary care, because physicians have been on the line. They have been borderline about to drop Medicaid. All the physicians that have been on Medicaid are simply there on dedication, not because they make money. Physicians have all said I will hang on a little longer, maybe something will improve, if not, I will drop Medicaid.

Without their 15 percent increase, which is what would go if you lost the voluntary contribution, there is a real question how the tertiary hospitals, the medical center, Detroit Medical Center, and the physicians who provide tertiary care would be able to take care of Medicaid patients. Real serious question.

Mr. DINGELL. This promotes a comment that probably you ought to have in mind. The program expires the last day of this year. The election is early in November. There will be no post-election session for Congress. I would suggest that the crisis is postponed by the enactment of this legislation until after the election. I would suggest if the hospital association and medical association want that addressed, they should trigger a crisis before, rather than after the election. I leave that thought in your mind.

Mr. Hiltz?

Mr. HILTZ. If you live in Epsilon or Flint, Michigan, we are in a crisis. I think in Monroe we have a pretty good school system. Last fall, during midterms they arranged parent-teacher conferences, so they had all the teachers in the gym, and they scheduled the sessions during the day and at night. Less than 30 percent of the parents showed up to get involved in the quality of education for the kids.

In this country, one State stands out as doing a pretty super job with education and in high values for medical care and quality of life. It is the State of Utah. The State of Utah is dominated by a church that holds family to be of critical importance.

Can our country continue to prosper and recover if we don't get some of those values back? It invades health care, it controls education, and that is what we are all about. We have got to do something. We have to decide which direction we are going to go. Look at Utah. Why are they so good? It is because of the values they have. Healthy women, emphasis on education, emphasis on family.

Mr. DINGELL. Doctor, do you have any further comments?

Ms. ADELMAN. Primary comment is that we in medicine are vitally interested in working with you on this problem. I don't think we have said everything we know today. We do know more. We have a great deal more written out. We have a great deal of elaboration on the material we have prepared. The AMA has several councils and work groups and would have you working on many areas that are not flushed out.

The cost containment area needs more work, catastrophic needs more work, long-term needs more work in our proposals. We are extremely interested in being supportive of your work and working with you.

Mr. DINGELL. Thank you.

Mr. Ellstein? Mr. Hiltz?

Mr. HILTZ. I would echo Dr. Adelman. We are all interested in working with you.

Mr. ELLSTEIN. Particularly the Michigan members of the committee know where to find me. You found me before. And I do know I found your offices as well. We look forward to continuing the debate.

I think the one thing, having sat here all day, the one thing that has been demonstrated clearly is that the system is broken. We have heard endless evidence that the system is broken. It is time to move beyond trying to determine whether the system is broken. It is time to start moving into the discussion of how we are going to fix it.

Mr. DINGELL. Unfortunately you are right.

Doctor, Mr. Hiltz, Mr. Ellstein, the committee thanks you. The Chair notes this completes our panels of witnesses. The Chair wants to express my thanks, first to my colleagues for their patience and their diligence and attendance. Second, to all our witnesses for all their fine testimony; third, for the others who have participated and who have sat with us through the day observing what has been going on here.

Last of all, I wanted to say a word of thanks to the staff, the staff of the subcommittee, the full committee, but also the minority staff. I want the minority staff to know their cooperation in this has been noted by the Chair and is very much appreciated. It is a good example of not only the committee functioning but also the staff of the committee functioning. I think we are well-served by people of this quality. I am particularly appreciative.

I would recognize any of my colleagues for a concluding statement, if they would like to make one at this time.

Mr. CONYERS. Thank you, Mr. Chairman. I am privileged to be able to join you on this very important subject. As you know, Government Operations, which I Chair, is working on it, too, and I have John Gorman and Ray Plowden from my staff who have worked very hard, too. I only wish my ranking minority member was here to see how you praised the minority and their staff because we have the House Administration budget coming up, and if we aren't in agreement, we may not get any bucks for Government Operations. So you set an enormously good example for the other Chairman to follow.

Mr. DINGELL. I would answer that by saying we have a committee which has strong views. The Democrats and Republicans both have strong views which are not always in conformity one with the other, and we occasionally have vigorous interactions, but we work very hard.

I should make one observation. As Chair, I inquire of the minority what it is they want, and I present it in full to the House Administration Committee without any change. That will be my practice. That will continue to be my practice.

I wanted to thank Mr. Schaefer, who I know comes from far away from us, and Mr. Upton, who is of this State. Both of whom are of enormous value to this committee.

Mr. Schaefer?

Mr. SCHAEFER. I thank you for the opportunity to be here. I probably learned more about this situation than I care to know. I don't think anybody has any answers yet. Therefore, this was very informative. It was well set up. Information came from a number of different sources.

As I indicated last April, I had the first health conference in Colorado we ever had, bringing in all groups, trying to come up with possible solutions. I thank you for your leadership on this and recognize we do have a tremendous problem here, and as my colleague, also from Michigan said, it is time to blow this one up and start over again.

Thank you very much.

Mr. DINGELL. Mr. Upton?

Mr. UPTON. I would like to say one brief thing. I, too, commend the staffs on both sides of the aisle. It has been very clear from the onset, certainly since I have been on the committee, there is great harmony between both sides. I appreciate the cordial hard work so many people put in.

The other thing I would like to say, I again congratulate you on having a very good hearing back here. I have said so many times, the Congress may be criticized for factfinding missions in various places of the world, and I appreciate, certainly, Mr. Schaefer's attendance—all day attendance here—to bring home the problems of Michigan to the entire Congress. Whether it was the hearing today or whether it was your leadership last spring where nearly 10 percent of the Congress came to the Detroit area to study the problems of the automobile industry, many of them with a health-related focus, I think is certainly very commendable and helps us get the job done right when we go back and begin to work on legislation.

I thank you again.

Mr. DINGELL. The Chair thanks the gentleman.

The committee will stand adjourned until the call of the Chair.

[Whereupon, at 4:25 p.m., the hearing was adjourned, to reconvene at the call of the Chair.]

MEDICAID PROGRAM INVESTIGATION

THURSDAY, MARCH 26, 1992

House of Representatives,
Committee on Energy and Commerce,
Subcommittee on Oversight and Investigations,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:03 a.m., in room 2322, Rayburn House Office Building, Hon. John D. Dingell (chairman) presiding.

Mr. Dingell. The subcommittee will come to order.

The Chair has a lengthy opening statement which will not be read in view of the time constraints. This is what I view as a very important hearing today, looking into the overall question of how our health care system works, with very specific emphasis on Medicaid and how it is working in the midst of a huge increase in health care costs, how much of the health care costs this program is meeting, how well the American people are going to be served, and whether the system is going to provide the needs and the necessities of this country in the area of health care as we move into the first decade of the 21st century.

The Chair wants to just say that I am particularly pleased to have an old friend before the committee today. I will conclude my remarks after I have recognized Mr. Bilirakis for the purposes of introducing our first witness and I know he will do so with the same enthusiasm and warmth and good feeling that I feel towards the Governor.

[The opening statement of Chairman Dingell follows:]

Opening Statement of Hon. John D. Dingell

Over the course of the last year, the subcommittee has been conducting investigations into how our health care system works, who benefits from it and who loses, and why it is pushing us to the financial brink while our public health deteriorates and many more are going without health care. We repeatedly have heard the consistent message from physicians, hospital administrators, public health experts, patients and government officials that we have a system in crisis. The subcommittee has focused much of its attention on the Medicaid program because it was created to help our most vulnerable people—the poor, disabled and the elderly. And we focused on it because it appears to be at the most immediate risk of breaking apart and taking countless people and States down with it.

Unfortunately, we have also found that Medicaid's problems mirror those of our entire health care delivery system. Those problems reflect the unchecked growth of a $700 billion plus medical-industrial complex that is crippling our economy and shortchanging our citizens. It is truly shocking that nearly 40,000 of our children die each year—and that they are dying in a country that leads the world in medical technology and scientific research. While infant mortality is only one indication of the success of a health care system, it is a particularly sad testament of a system's failures.

Each morning, our televisions, newspapers and radios greet us with bleak news—nearly 20 percent of our children are living in poverty, 48 million Americans are going without health insurance, AIDS cases are projected to triple in the District of Columbia by 1996, and cases of dangerous, drug-resistant strains of tuberculosis are spreading across the country. Yet, we still cannot reach consensus on a coherent health care policy. We cannot afford to allow partisan politics and parochial interests to dictate what we do on this issue of critical importance to all Americans.

Today, we are fortunate to have with us Governor Lawton Chiles of the State of Florida. The Governor has long been in the forefront, both in his years in the U.S. Senate and in the State Capitol, trying to develop public health policies to help all of our citizens. I am particularly pleased to have him with us because Governor Chiles recently has succeeded in getting bipartisan support for major health care reform initiatives in his State. While the Governor has modestly suggested that Florida simply did not have the luxury of waiting any longer, his State is still unique in its courage in confronting these difficult problems. Let me take a moment to outline a few of the factors that the Florida legislators and the Governor faced:

—Florida has the highest percentage of elderly people, with their corresponding health needs, of any State in the country;

—The State has 2 million citizens living below the poverty line;

—Nearly 23 percent of Florida's non-elderly people do not have insurance, with a full 75 percent of those being workers and their dependents;

—Ninety-five percent of Florida's businesses employ fewer than 25 people;

—Florida has the second highest unemployment rate in the Nation; and, finally,

—Health insurance premiums increased 234 percent from 1980 to 1990.

We look forward to Governor Chiles' testimony and particularly appreciate his being with us today.

We are fortunate to have with us, as well, Ms. Rae Grad, the Executive Director of the National Commission to Prevent Infant Mortality. This Commission has made invaluable contributions over the years to the fight to save our most vulnerable citizens.

Ms. Grad will give us the alarming results of the Commission's newest analysis of trends in infant mortality and low birthweight babies. Her work and that of the Commission is essential to our understanding why the system is breaking down and what can and must be done to fix it.

I also want to commend my good friend and colleague from Georgia, Dr. Rowland, for his work on these important matters. Dr. Rowland is Vice Chairman of the Commission and he also sits on the President's Commission on AIDS. His insight on these crucial issues will be invaluable in our hearing today and as we move forward with our work.

Finally, today we will hear from Mr. Michael Mangano, the Deputy Inspector General for the Department of Health and Human Services. Following the subcommittee's first hearing in June of last year, the Inspector General was requested to conduct additional investigations for the subcommittee. That work has been completed and Mr. Mangano will report to the subcommittee on those findings. Specifically, the Inspector General evaluated the economic and public health consequences of patients going to emergency rooms across the country for primary health care. He also reviewed how managed care affected both the quality of care and cost of health care for Medicaid patients. And finally, the Inspector General assessed the extent and nature of the "hassle factor"—the paperwork and logistical nightmare that many physicians claim is one of the primary reasons they will not take Medicaid patients.

We are pleased to have all of you with us today. I believe that the record that you are helping the subcommittee build will be of critical importance in our efforts to respond to the health care crisis.

INTRODUCTORY REMARKS OF HON. MICHAEL BILIRAKIS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. Bilirakis. Thank you, Mr. Chairman, and good morning.

As a former member of this subcommittee, Mr. Chairman, and I do miss working with this subcommittee I might add, as a Floridian and as a Gator I truly appreciate the opportunity to introduce to you the Governor of the Sunshine State, Governor Lawton Chiles.

Governor Chiles has served the people of Florida for 33 years. After serving in the State House and Senate, he was elected to the U.S. Senate in 1970. He became the first Floridian to chair a major Senate committee, the Budget Committee, and for years fought for budgetary discipline, but Lawton's determination to rein in Federal spending, Mr. Chairman, did not restrict his vision. He recognized years ago that too many children in the United States did not live to celebrate their first birthdays and that even more tragic, most infant deaths were preventable.

Governor Chiles was instrumental in founding the National Commission to prevent infant mortality and has served as its chairman ever since. Mr. Chairman, as we might imagine, few individuals who will ever testify before this subcommittee can speak with the authority on the subject of infant mortality as our Governor, Lawton Chiles.

I support the Medicaid program. I know that we all do and we all want to preserve it. However, Federal regulations and mandates placed on the Medicaid program by Congress have created serious difficulties for most States, Mr. Chairman, and I know we are going to hear more about that here this morning. I honestly do not believe it is the intent of Congress to put States in this position. However, that has been the outcome in many States.

Getting back to the subject of infant mortality, Mr. Chairman, the Governor and I share the dismal infant mortality rates of our Nation especially in the southern region. Since 1989 I have served as the co-chairman of the Congressional Sun Belt Caucus Task Force on Infant Mortality with my good friend Roy Rowland, who has just come in.

The Task Force is quite active because we are deeply concerned. The Sun Belt region has the highest infant mortality rate, I am ashamed to say, of any area of the country. In my Congressional district the news is more encouraging, as the Governor knows. There has been a noticeable reduction in infant mortality rates for Pasco County, for instance, since the mid-1980's. Nutrition programs which most of us strongly support can make a significant difference in the lives of so many.

I am proud to say the Pasco County program goes that extra mile and while providing nutritional services, the staff takes a personal interest in every client. I have visited those facilities, some of those facilities, Governor, and I have seen actually the personal interest that they take. It's just a wonderful thing to see.

Providing pregnant women with adequate prenatal care is another proven method which lowers infant mortality statistics. Unfortunately, skyrocketing medical malpractice insurance premiums have led many obstetric providers to refuse to accept Medicaid recipients as patients or refuse to accept new patients altogether.

Last year I introduced the Access to Obstetric Care Act of 1991 in an effort to encourage more health care professionals to provide services to all pregnant women. This bill would allocate funds for Medicaid demonstration projects at the State level to enable States to design initiatives tailored to meet the exact needs of their residents.

Mr. Chairman, there are many other aspects of the Medicaid program which I am deeply interested in, particularly preventative health care for all ages, and also long-term care.

Health care reform is necessary in this country and all of us have different ideas on how to resolve this very serious matter and I guess that is part of the problem—we all have different ideas.

The Governor and I both believe that every American has the right to health care access. I am certain the Governor will be able to provide this subcommittee with valuable insights on the Medicaid program, on infant mortality and health care access issues.

I am pleased, Mr. Chairman, to introduce to the committee our Governor, Lawton Chiles, and am further pleased to see your interest and the committee's interest in the Medicaid program and would be more than willing to work with you on these very important issues.

I am pleased to introduce to the committee Governor Lawton Chiles.

Mr. DINGELL. Governor, before we recognize you, our good friend Mr. Rowland is here and I know he would like to have something to say at this particular time.

Mr. ROWLAND. Well, what a pleasure to see you, Governor Chiles. I am really pleased that you are here. I don't believe there is anyone in this country that would be more familiar with the problems that confront us today in the Medicaid programs and in teenage pregnancy than you. You have been here at the Federal level. You are at the State level now and I believe that your understanding of the problem will shed a great deal of light on what we need to do.

It is certainly a conundrum to know how to deal with this problem with the increasing number of teenage and adolescent pregnancies that we have. We continue to have one of the poorest infant mortality rates in the world and the fact is that my own State of Georgia is the worst State in this country with reference to infant mortality, 40 percent of the deliveries in my State of Georgia is in the Medicaid program. I have not voted for any expansion or supported any expansion of Medicaid without talking to the people back in my home State about this.

We have a propensity here in Congress to put burdens on the States or create or expand programs that in many instances just don't work. They don't do what they are intended to do. I am so pleased to see you here today, and I look forward with great anticipation to what you have to say.

Thank you.

Thank you, Mr. Chairman.

Mr. DINGELL. I just want to add to you, Governor, that as a personal friend of yours and as an admirer of yours for a long time, as one who served with you while you served your State with distinction in the Senate and one who has worked with you and under your leadership on the problems of health and young people and infants, and recalling all of the wonderful things that you have done, I want to tell you that it is a particular honor and a pleasure for this committee to have you before us to testify.

There are a couple of minor things. We have precedents in this place, as you very well know. The first is that we receive all testimony under oath.

Would you have any objection to being sworn?

Governor Chiles. No, sir.

[Witness sworn.]

Mr. Dingell. Governor, welcome to you. You may proceed in any fashion you choose.

TESTIMONY OF HON. LAWTON CHILES, GOVERNOR, STATE OF FLORIDA

Governor Chiles. Thank you, Chairman Dingell, and to my good friend Representative Roy Rowland, who co-chairs the Infant Mortality Commission with me. I am delighted to have a chance to be here and today especially as we make an infant mortality report, which Rae Grad will make, and to my good friend, Congressman Mike Bilirakis, I thank you for those kind words.

Governor Waihee could not be here today but he asked me to submit his testimony for the record and I would like to do that.

Mr. Dingell. Without objection, that will be inserted at the appropriate place. [See p. 457.]

Governor Chiles. Hawaii's pre-paid health plan, health care act, is a comprehensive full-access program that sets the standard for all States and so I submit that.

Mr. Chairman, before I begin my testimony, knowing of your interest in protecting against certain predators, I wanted to report to you that last Sunday morning I had an opportunity to be in the area of a marauder. I thought I had picked my position well. Following the example of Southern military tradition, I had tried to pick my ground. I had camouflaged my position. I thought I had defended it adequately but this particular marauder without saying a word slipped in behind me, almost assaulted me. Fortunately, right won out and I was able to dispatch this predator. I just wanted to let you know you are one behind unless you have started already.

Mr. Dingell. I am delighted to know that you were able to defend yourself.

Governor Chiles. Yes, sir. Having shared you all's responsibilities and your point of view for awhile, maybe I feel a little like Paul after having persecuted Christians for awhile. He felt the Lord had given him a particular load to carry and I have the opportunity to do that in my second chance now in my trying to serve 13 million Floridians but 2.5 million of those have no access to affordable health care. These are mainly working folks. They are not permanently in this status. In fact, and that is the heck of it because but for a marginal change in circumstances any one of us could sort of be where a number of them are, and I would like to share with you just a few of their stories.

The Wauchula family was forced to sell their farm and all their belongings to pay for the medical care of their 10-year-old daughter. A 40-year-old Miami motel maid was denied surgery at a public hospital because she could not afford the $200 deposit. She made too much money to qualify for Medicaid, too little to buy insurance, and her job did not offer an insurance plan.

We have a case of a 14-year-old Palmetto girl, committed suicide after being discharged from a crisis center. Her working parents were ineligible for Medicaid but had no health insurance and could not afford the private hospitalization that she needed.

An Indialantic family is on the verge of bankruptcy with $200,000 in hospital bills for their 15-year-old daughter who has cystic fibrosis. The family's insurance company stopped writing medical policies in Florida, leaving them uncovered.

It was these stories and thousands more that moved us to pass the Florida Health Plan, which calls for full access to affordable care to all Floridians by December of 1994.

Our plan ensures that every Floridian will have a family doctor with emphasis on a managed care delivery system. We pool the health care purchasing power of the State and local governments. We establish community-based health care promotion and wellness programs. We establish the Florida health services corps. We provide scholarship and loan repayment assistance to help professionals who serve in rural and medically-underserved areas. We prohibit the denial or non-renewable of small employer plans because of health status, claims experience, occupation or geographic location. We limit the premium rate increases among classes of employees and we impose a 12-month limitation on the exclusion of pre-existing conditions.

Mr. Chairman, I am a great believer in the free market and in incentives over mandates, but if I am to provide those incentives I need your help and additional flexibility.

Therefore, I am meeting with Members of Congress and the administration today to try to ask for the following Federal waivers:

We propose a Medicaid buy-in program that would allow Floridians who don't qualify for Medicaid under the current rules to have access to a program that uses Medicaid funds. To do this we need to remove the restrictions that tie Medicaid to other Federal aid programs like SSI or AFDC. We need to separate health care from welfare.

Mr. Rowland, Congressman Rowland, you pointed out what happens when States, many of whom are some of our Southern States, and it's hard when you give these mandates that we have to do everything. Then we can't afford the coverage. We know what happened to States when you gave us the ability, and I helped do it when I was up here, to get into the prenatal business without having to cover all of the other things. States opted and I think most have done it and it's certainly helped us tremendously in Florida. We are looking for this kind of a buy-in program to cover this 2.5 million uninsured people.

Another area we want to experiment is Medicare. I can't think of any good reason why the States are given the authority to administer the Medicaid program, yet the Federal Government insists on managing Medicare. We want you to authorize Federal demonstration projects using alternative payment mechanisms including single payer systems. We want the authority to use Medicare funding for managed care programs. It will cut the overall cost. Again, if we can share in the savings, we can enhance these programs and reach more people with better services.

We also want to amend the Employment Retirement Income Security Act, ERISA. This act prohibits the States from regulating self-funded insurers. Understandably, there are many groups including labor and business who want to avoid having to negotiate different insurance benefits in every State. Again, we think there is room for a compromise that will allow Florida to mandate certain benefits and experiment with the single payer.

The leverage of a pay-or-play plan would give us the pressure to get the voluntary compliance that we feel that we need and if we cannot get some kind of leverage off of getting the ERISA waivers, our goal towards trying to get there on a voluntary basis just isn't going to happen because this gives us the hammer. Congress and you, Mr. Chairman, have talked about pay-or-play. The ability of us to have the hammer by having the ERISA waivers, is tremendously important, we think, to us being able to follow through.

Finally, there are several other administrative efficiencies that can be achieved that would greatly enhance our ability to better serve Floridians and save both Federal Government and our State dollars. Those initiatives include the elimination of waiver requirements for home and community based services for the developmentally disabled and elderly people of Florida, expanding managed care programs as well as the development of a system of accountability that avoids the nit-picking that results from audit and documentation requirements that are a hindrance to effective government.

Mr. Chairman, in a nutshell, we have got many areas in which waivers have been granted not only to Florida but a number of States, and yet every 2 or 3 years we have to go through the same process. It is very expensive, very time consuming to try to get the same waiver that we have already been given that we know works and that just does not make sense.

Just to give you an example, it took us 28 months to get a waiver to be able to treat AIDS patients at home under and using some of the Federal funds as opposed to keeping them in a hospital setting where it costs the Federal Government and the State government much more money, 28 months.

Mr. DINGELL. Governor, I don't often do this, but I think your comment here is important enough that it ought to be addressed immediately.

Your assistance in framing the particular complaints that you and the State of Florida have had with this waiver process would be immensely useful.

Governor CHILES. Fine.

Mr. DINGELL. This is a matter of special concern to this subcommittee and we are going to be having the Secretary before us shortly. We are in the process of writing budget legislation and dealing with questions of that sort which would enable us, as you would know in your experience, to proceed to write certain changes into either the administration's or into the statutory body of law. Your assistance in this particular arena would be of great help to us. So if you could get your State officers who deal with this matter to give us your specific set of concerns and complaints, it would enable us to better serve you and other States.

Governor CHILES. Mr. Chairman, we will have that to you immediately.

Mr. DINGELL. Thank you, Governor.

Governor CHILES. We can do that, yes, sir.

Expanding managed care programs as well as the development of the system of accountability—I already covered that.

Our Constitution guarantees all of us the right of free speech and every State provides its citizens with the right to public education. With your help, the fourth largest State in the country is willing to try to extend the right of affordable health care to all of its citizens. We can be your laboratory.

Our people have spoken. They want Government to ensure health care for all. There is neither an easy solution nor single solution and many difficult steps must be taken to recast our health care system into one that is effective, economical and available to all.

Our job, mine and yours, is to aggressively tackle the remaining problems and find the path to true health care reform. Further delay is the one thing that's no longer acceptable to our people. I am convinced that the solution lies in granting the States the additional flexibility that they need to test their innovative health reform programs.

[Testimony resumes on p. 384.]

[The prepared statement of Mr. Chiles follows:]

STATEMENT BY
The Honorable Lawton Chiles
Governor of the State of Florida
Presented Before the
Subcommittee on
Oversight and Investigations
Committee on Energy and Commerce
U.S. House of Representatives
March 26, 1992

Chairman Dingell, Representative Bliley, and members of the Subcommittee:

Thank you for inviting me here today. Governor Waihee could not be here today, but he asked me to submit his testimony for the record. Hawaii's Prepaid Health Care Act is a comprehensive, full access program that sets a standard for all states.

I always welcome the chance to meet with my former colleagues of many years, although I must say that serving as governor of the fourth largest state has changed some of my perceptions of governing. I appreciate this opportunity to testify on what may be the most critical long-term issue facing Americans today. This time, however, I am on the other side of the table seeking the Congressional action I need to fully implement Florida's Health Care

Reform Act of 1992, legislation that contains my comprehensive health care reform plan. On Tuesday, I signed the bill into law.

I am also here today to testify on behalf of some of Florida's two and one-half million uninsured people who do not often get the opportunity to tell their stories. But they are stories that must be told.

- A Wauchula family was forced to sell their farm and all their belongings to pay for medical care for their 10-year-old daughter.
- A 40-year-old Miami motel maid was denied surgery at a public hospital because she could not afford a $200 deposit. She made too much money to qualify for Medicaid, too little to buy insurance, and her job did not offer an insurance plan.
- A 14-year-old Palmetto girl committed suicide after being discharged from a crisis center. Her working parents, ineligible for Medicaid, had no health insurance and could not afford the private hospitalization she needed.
- An Indialantic family is on the verge of bankruptcy with $200,000 in hospital bills for their 15-year-old daughter who has cystic fibrosis. The family's insurance company stopped writing medical policies in Florida, leaving them uncovered.

- A St. Petersburg couple's chronically ill 3-year-old daughter lost federal disability benefits and state Medicaid assistance in the months when her father received five weekly paychecks. His employer-sponsored family policy expired after his daughter received only 18 months of care.
- A Safety Harbor mother was left with $15,000 in medical bills after the birth of her baby because her employer's self-funded insurance plan ran out of money, even though she had paid over $1,000 in premiums during her maternity leave.
- A 61-year-old Boca Raton woman must pay $5,000 per year to Florida's high-risk pool for insurance with a $5,000 deductible. Hospitalized for months after a car crash 8 years ago, she is now considered a bad risk by insurance companies, even though she is in good health and has a healthy lifestyle.

These snapshots from the front lines of our health insurance crisis bring the problem into focus. Florida's uninsured are the employees of small and medium-sized businesses that either choose not to offer coverage, or cannot afford to do so because of health insurers' underwriting practices. They are people with low-incomes who do not work but are ineligible for Medicaid. They are disabled persons who can no longer work or who have their insurance cancelled by carriers who deem them unacceptable risks. Tragically, far too many are our children who are denied a healthy start in life because their parents cannot afford health care.

The effects of decades of steadily rising health care costs can no longer be ignored. More and more of our citizens are finding their basic access to health services severely limited by their inability to purchase affordable insurance. They are forced to delay seeking care until they have no choice other than a sudden visit to an overcrowded hospital emergency room. More and more Floridians feel they have nowhere to turn when they need medical attention.

But this is not simply a problem for consumers. No one who finances or delivers health care is exempt from the effects of the crisis:

- For government, commitments to fund increasingly expensive health care programs leave less revenue to fund other critical needs, such as education, the environment, and criminal justice.
- For business, rising health care costs contribute to a decreased ability to compete in the global marketplace, as prices are continually boosted to cover higher employee benefit costs. With such a large portion of revenues being

diverted to health benefits, less capital is available for research and development or long-term investment.

- For hospitals and other providers, growing numbers of uninsured patients lead to increased cost-shifting, which helps decrease the effect of bad debt, but inflates the bills of those patients who can pay.

There are many national health care reform proposals, ranging from incremental reforms to employer mandates and universal health care programs. As a poll of New Hampshire presidential primary voters recently documented, the public, although dissatisfied with the current health care system, has not endorsed any of the national plans being proposed (Kaiser Family Foundation, 1992). Although I would prefer a national solution to the health care problem, the federal government should encourage states to test alternative designs before it decides which system is best for the entire country and enacts major social legislation that will affect the lives of all Americans (Wolfson, 1988).

Before I turn to the statutory and regulatory reforms Florida needs to fully implement its health plan, I would like to take a few moments to summarize our health problems and my response to the state's crisis.

Florida's Health Care Problems

Unique population characteristics make Florida an ideal site to test health care reform. Our state has the highest percentage of elders in the nation with 18.4 percent of the population aged 65 and older. It has the third largest black population and the third highest percentage of migrants and refugees. Approximately 12 percent of the state's population is of Hispanic origin (U.S. Department of Commerce, 1991a). Besides this diverse population, Florida also has almost 2 million residents who live in poverty (U.S. Department of Commerce, 1991b). This is significant because studies show that people with low incomes are more likely to report their health as poor or fair than those with higher incomes.

Uninsurance

The nation's health care problems are magnified in Florida. Most Floridians have insurance, but two and one-half million residents, 18.5 percent of the population, are uninsured; 75 percent are workers and their dependents, and almost one-third are children (Florida Task Force on Private Sector Health Care Responsibility, 1991). Florida has the nation's third highest percentage of non-elderly uninsured residents--22.9 percent (EBRI, 1992). Its percentage of non-elderly uninsured is also higher than the 18.7 average of other Deep South states. Florida data from national studies show that uninsurance is highest among blacks, males, people with incomes below $25,000, and those between the ages of 18-39 (Himmelstein, 1992).

Employer-Based Insurance

Since employment is the most important determinant of health insurance coverage, part of Florida's high uninsurance rate can be explained by the characteristics of its business community. Large businesses are more likely to offer health insurance as a fringe benefit than small businesses. But 95 percent of Florida's businesses employ fewer than 25 people. Among firms with 5 to 9 employees, 32.3 percent are uninsured. In even smaller firms (i.e., fewer than 5 employees), 60 percent are not covered (Florida Health Care Cost Containment Board, 1990a).

Workers in government, mining, finance, insurance, and real estate are most likely to be insured (EBRI, 1992), but these industries represent only 22.4 percent of Florida's job market. Workers are least likely to be insured if they are self-employed or work in agriculture, construction, retail trade, or services (EBRI, 1992). Florida's largest industries are services and retail trade, representing almost 49 percent of the state's 1990 work force (Florida Department of Labor and Employment Security, 1991). Between 1990 and 2000, Florida will create an estimated 2.4 million new jobs, over half of which will be in service and retail trade occupations where insurance is lowest (Florida Task Force on Private Sector Health Care Responsibility, 1991).

Florida has the second highest rate of unemployment in the nation -- 8.7 percent (U.S. Department of Labor, 1992). Recent layoffs by employers who typically offer health insurance (e.g., airlines, banking, and government) also contribute to the state's burgeoning uninsurance problem.

Health Care Costs

Health care costs must be brought under control to make health care available to all Floridians. As in the rest of the U.S., Florida's overall health care costs are far outstripping general inflation. An aging population, unhealthy lifestyles, a lack of access to early primary and preventive care, and proliferating medical technology combined with inappropriate use of health care services, excess hospital capacity, and fee-for-service reimbursement contribute to increasing costs. Nationally, the costs of employer paid health benefits have risen three times faster than wages since 1980. Employee wages and business profitability are constrained by every dollar spent on health care. Between 1980 and 1990, Florida's health care expenditures increased by 234 percent, from $9.4 billion to $31.4 billion. By 2000, expenditures are projected to reach as high as $90 billion (Florida Task Force on Private Sector Health Care Responsibility, 1991).

Florida's health care inflation rate has consistently exceeded the national rate as measured by the U.S. Consumer Price Index component for hospitals and related services. From 1988 to 1989, the state's health care costs increased 16.6 percent, compared to 11.5 percent nationally (Health Care Cost Containment Board, 1991). Florida Medicaid expenditures are also an indicator of the problem. Medicaid's $4.1 billion budget, which has tripled in the last six years, is expected to account for 14 percent of the state's total budget in FY 1991-92. Conservative projections anticipate that it will triple again to $13.7 billion by FY 2000-2001; and based on the most recent four-year trend data, expenditures could conceivably reach $20 billion by 2000.

On average, Florida families spent $3,392 on health care in 1991, accounting for 11.9 percent of their income. By 2000, family health spending is projected to more than double to $8,235 (Families USA, 1991). For high-risk individuals, the problem is worse. Enrollment in Florida's high-risk health insurance pool is limited to about 7,500, and premiums represent approximately 20.2 percent of enrollees' total income. About 65 percent of the risk pool's policy cancellations are for nonpayment of premiums. High medical costs are also a factor in the growing number of personal bankruptcy filings. According to the American Bankruptcy Institute, Florida ranked third in the rate of increase in bankruptcy cases between 1985 and 1991.

A study conducted by the Congressional Budget Office suggested that " a major reason for high and rapidly rising health costs may be the failure of the normal discipline of the marketplace" (Congressional Budget Office, April 1991). Insurance companies have added layers of employees to scrutinize virtually all medical bills. Prior approval is needed before hospital care or expensive treatments are performed. Physicians are spending an increasing amount of unproductive time completing forms and explaining their actions to reviewers in distant offices. Our health care system is also overloaded with expensive, underused hospital facilities. In 1990, Florida's acute care hospitals reported an average occupancy rate of only 52.5 percent (Florida Department of Health and Rehabilitative Services, 1991). Acute care facilities are engaged in a technological arms race to obtain new diagnostic and therapeutic equipment that attracts specialty physicians and their patients.

Rapidly rising health care costs are pushing us to the brink of disaster. If costs increase as projected, major government and private sector employers will be forced to join small businesses in curtailing health care benefits and expenditures. In 1990, corporations saw a 27 percent increase to their health care bill that had nothing to do with services for their workers (Stuart Altman, personal communication, 1991). We must bring costs under control. In neighborhoods across the nation, high costs for health care mean that:

- uninsured people use fewer health services and, as a group, have more illness to cope with;
- families are going bankrupt trying to pay medical bills; and
- hospitals and other providers are less willing and able to provide free care.

Health Status

Despite enormous expenditures on health care, the health status of many Floridians, particularly the youngest ones, has not improved proportionately. In 1988, Florida ranked only 34th in its infant mortality rate, 47th in the percentage of babies born to mothers receiving early prenatal care, and 39th in low birthweight babies. One of every 13 Florida births is under 2,500 grams. One of eight births to mothers under age 18 is low weight. About 1,800 infants die in Florida every year before their first birthday. Statistics such as these cast doubt on the value of our health care investment.

Other health status indicators present an equally unfortunate picture. Although TB cases have increased by 7.3 percent since 1987, federal TB funding has declined by more than 63 percent. Florida ranks third nationally in the number of AIDS cases. AIDS is now the eighth leading cause of death in Florida. It is estimated that another 120,000 Floridians are infected with HIV. Although AIDS cases increased by 45 percent from 1990 to 1991, federal funding for the same period declined. The cancer death rate has increased every year since 1979. From 1981 to 1989, crude breast cancer rates increased by almost 17 percent from 112 to 131 per 100,0000, while crude cervical cancer rates dropped slightly from 13.82 to 12.48 per 100,000. Heart disease and strokes kill over 50,000 Floridians every year. Our apparent inability to significantly improve health status, even with our awesome investment in health services, is one of the reasons I feel that comprehensive rather than incremental reform has become necessary.

Previous Health Reforms

Measured by its benefit package, the percentage of low-income population enrolled, and the extent of its provider network, Florida had one of the nation's most limited Medicaid Programs in the early 1980s. With the passage of the Health Care Access Act in 1984, the state launched its first major health care access and financing revolution. Florida aggressively pursued major Medicaid expansions throughout the 1980s, maximizing federal funding to enhance services and cover additional groups. Some optional coverages implemented in Florida were later mandated by Congress. From 1980 to

1990, Florida had the largest percentage increase of all states in its share of Medicaid expenditures. The state also implemented many other health insurance, cost containment, and primary care reforms, based on the expert advice of numerous health care task forces.

Florida has pioneered several health care reform strategies, including provider assessments to finance Medicaid expansions, disproportionate share hospital reimbursement, the Improved Pregnancy Outcome Program, health care networks for chronically ill and disabled children, and large-scale primary care programs in county public health units.

Traditionally, Florida has relied on employer-based health insurance because the majority of insured Floridians are covered through the workplace. Many of the state's innovations build on this tradition. With Robert Wood Johnson Foundation funding, the state has developed nationally recognized programs to address the uninsurance problem. The Healthy Kids Corporation is the first school-based health insurance program for children. The Florida Health Access Corporation (FHAC) functions as an intermediary, negotiator, and insurance cooperative for Florida's small businesses. It now operates in 16 of Florida's 67 counties and insures 10,000 enrollees in 2,300 small businesses, reaching about 7 percent of the small employer market.

Florida is the first state to test a government-sponsored, private non-profit corporate health care purchasing cooperative, authorized by the 1991 Florida Legislature. The Florida Healthcare Purchasing Cooperative (FHPC) will act as a pooled purchaser for state and local governments and private businesses, particularly state contractors and small businesses. It will aid private business alliances and assist them in restructuring local health care systems to improve quality of care. Within five years the cooperative is expected to serve 50 percent of governmental employers and 10 percent of eligible private employers, saving millions of dollars.

In recent years, Florida has enacted significant small business health insurance reforms, including a prohibition on the unilateral cancellation or non-renewal of coverage, limits on premium increases, increases in the minimum percentage of total premiums that must be paid out as benefits, limits on premium increases due to expenses, and requirements that insurers combine smaller groups for rating purposes.

Finally, the 1992 Florida Legislature has just passed model joint ventures legislation prohibiting health care providers from referring patients to laboratories, diagnostic centers, or any other health service organization in which the referring provider is a major investor.

Healthy Start Initiative

I cannot think of a better way to illustrate why we must succeed with our reform plans in Florida than to share with you the most recent report of the National Commission to Prevent Infant Mortality that we are releasing here today, Troubling Trends Persist: Shortchanging America's Next Generation. In a moment, the Executive Director of the Commission, Rae Grad, will more fully discuss the report in her testimony.

Almost two years ago to the day, the Commission released another report, also called Troubling Trends, in which we tried to sound a loud and clear warning to the nation about the poor state of maternal, infant. and child health, and what could be done to improve the trends. Well, since we are here today with this report, it seems that the alarm wasn't loud enough. Not only is the nation's progress exceedingly slow in a number of areas, we are actually going in reverse in many of them.

This cannot continue if we want to have healthy families, children able to learn in school, and a productive workforce in the next century. It's too costly, in terms of money, human suffering, and lost potential.

I am proud to report that we have heard the message in Florida and have responded with our Healthy Start program. Healthy Start has one major aim -- to assure that all women have ready access to adequate prenatal care and that their infants receive the health care they need. I am proud of Healthy Start because it is evidence that we in government can be flexible and creative and make use of many tried and true ideas that are already working out there, but that have not been able to find their way through the bureaucracy and the red tape.

Beginning in April, all pregnant women and infants in Florida will be screened for risk factors that could have negative effects on their health. We will also expand programs to serve the health care needs of those patients who have defects identified through screening. Effective May 1, Florida Medicaid eligibility will be increased from 150 percent to 185 percent of the federal poverty level for pregnant women and children under age 1. In June, the Medicaid reimbursement rate for obstetrical care will increase to encourage more providers to serve low-income patients. Florida has already reduced its infant mortality rate from 11.3 deaths per 1,000 births in 1985 to 9.6 deaths per 1,000 births in 1990. I am convinced we will make further improvements to the Healthy Start program as we gain additional experience with these interventions.

Florida Health Plan

Medicaid expansions have greatly improved public coverages in Florida, but they have proved to be a double-edged sword. Medicaid now consumes much of the state's new general revenues each year--and the pressure to expand will continue as the population ages. Despite improved public coverages, major segments of Florida's population remain uninsured. It is now clear that Florida must attack the entire problem, rather than focusing on only a few elements. Although I would prefer a national solution to the health care crisis, Florida can no longer wait on federal action.

In January, 1992, I announced a comprehensive health care reform proposal, the Florida Health Plan, to ensure access for all Floridians by December 31, 1994. For the first time, Florida has announced as a matter of public policy that every resident of the state will be ensured access to health care.

In enacting the legislation, which passed the Senate by a vote of 35 to 2 and the House of Representatives by a vote of 109 to 0, the Florida Legislature found that:

- Health care inflation, a deteriorating health care delivery system, reduced state revenues, changing demographics, and the erosion of private health insurance have converged to create a crisis of reduced access for the poor and the uninsured.

- Access to health care is an increasing problem for many Floridians, especially for women and young children, part-time employees, employees of small businesses, and the unemployed.
- The failure of Florida's health care system to be accessible to all residents is not only unacceptable to the Legislature for humanitarian reasons, but also because it results in inappropriate and far more costly use of health resources, a less productive work force, and a less effective educational system.
- Almost half of the uninsured are at or near poverty, requiring insurance reforms that significantly lower costs.
- Almost three-quarters of the uninsured are employed or are dependents of employees, and half of these uninsured are employed by small businesses.
- A competitive market is lacking in some areas of health care and, therefore, an appropriate level of regulation is necessary to ensure the quality, affordability, and availability of health care services.
- The problem of health care access cannot be solved with the simple expansion of existing programs, but requires major reform of the health care delivery system.

The Florida Health Plan was prepared specifically for our state's economy, reflecting its large percentage of small businesses, low-paying service sector occupations, and significant seasonal migrations. Because the plan is grounded in a knowledge of Florida's political and economic environment, it has found a receptive audience. Floridians tend to be conservative, prefer less government regulation, and support voluntary efforts to problem-solving.

The Florida Health Plan represents an appropriate Southern strategy for addressing the state's health care problems. The Health Care Reform Act of 1992 is a comprehensive, multi-strategy approach to health reform that includes the following major elements:

- First, over a two-year period, a new Agency for Health Care Administration will consolidate health care financing, purchasing, planning, and health facility, professional, and cost containment regulation. The agency will also supervise Medicaid and State Employee Health Insurance purchasing.
- Second, the new agency will be responsible for developing interim recommendations by December 31, 1992, and final recommendations by December 31, 1993 to fully implement the Florida Health Plan, provide access to basic health services for all Floridians by December 31, 1994, reform the health insurance system, limit health care cost increases to manageable levels, restructure health regulation, and establish a comprehensive health care

data base. The Florida Health Plan is to be developed over a two-year period, consistent with the following principles and strategies:

- ensure access to affordable basic benefits for all residents of the state regardless of health condition, age, sex, race, geographic location, employment, or economic status;
- ensure coverage of persons who are unable to obtain or afford health insurance coverage because of chronic or acute illnesses;
- distinguish the roles state and local government and employers should assume in the provision of health care services;
- ensure that by December 31, 1994, all employees and dependents have coverage for basic health care services or mandate that employers provide such coverage;
- preclude employer-mandated coverages until state cost containment goals have been met;
- reform private health insurance practices to ensure coverage for employees and their dependents, regardless of their health status and employer size;
- ensure that an appropriate number and distribution of health care facilities and health professionals are available throughout the state by January 1, 1996;
- provide fair reimbursement to health care providers in a timely and uncomplicated manner;
- ensure accessible health care services in rural and other medically underserved areas;
- promote the accessibility of primary and preventive care and control the proliferation of tertiary care;
- establish priorities for the use of limited resources, ensuring that higher priority is given to those programs that have been shown to produce good outcomes, secure a good value for their investment, and provide a healthy start for the state's youngest citizens;
- consolidate the administration of state-funded, state-administered, or state-sponsored health insurance programs;

- develop a public and private health insurance payer mechanism to simplify provider billing, reduce administrative overhead costs, and maximize government and third-party purchasing power;
- develop a system of handling medical negligence disputes that will ensure a more efficient and equitable method for determining damages and compensating injured parties;
- rely on private providers for the delivery of health services;
- ensure that all residents participate in a public or private plan;
- ensure that all residents contribute, based on their ability to pay, to the financing of their health insurance;
- provide basic health insurance benefits that promote healthier lifestyles, require people to assume greater responsibility for their health, and provide early diagnosis and treatment to avoid later and more costly medical interventions;
- implement managed care in public and private health insurance plans; and
- redesign market entry controls to provide uniformity across all health care providers, eliminate archaic or costly regulatory rules; limit regulation to those areas which require regulation due to limited market needs and high capitalization costs; and provide an appropriate level of regulation in areas where market forces have been unsuccessful in constraining rapidly escalating costs.

- Third, a unique voluntary private health insurance coverage and cost containment program will be implemented, including targets for measuring progress from July 1, 1992, through December 31, 1994.

- Fourth, fundamental market and structural reforms, including "play or pay" employer mandates, will be ready for implementation in 1995 if the voluntary program fails.

- Fifth, a single payer or limited regional payer system may be developed to reduce administrative costs and leverage volume discounts.
- Sixth, major small business health insurance reforms will be implemented. The legislation sets benefit standards; prohibits the denial or nonrenewal of small employer plans because of health status, claims experience, occupation, or geographic location; limits premium rate increases among classes of employers; imposes a 12-month limitation on the exclusion of preexisting conditions; reforms insurers' small business marketing practices; and establishes additional disclosure, advertising, and performance standards for long-term care insurance. It also creates a small employer health reinsurance program.
- Seventh, the legislation also tightens controls on hospital revenues and imposes larger penalties for failing to conform to state limits; establishes two new programs: a major statewide health promotion and wellness initiative and the Florida Health Services Corps, a health personnel deployment initiative; extends sovereign immunity to practitioners for providing uncompensated care to low-income, uninsured people; mandates state contractor insurance of their employees by July 1, 1994; restructures the state's health care delivery to rely on managed care and practice parameters to reduce the

costs of defensive medicine; and includes other health reforms to control health care facility capital costs.

The Florida Health Plan charts an ambitious agenda to alter the way the business of health care is conducted in Florida. Its principles will provide essential reference points for all the more detailed proposals that will be developed over the next few years. Businesses, providers, and insurers, will be asked to commit themselves to a goal of ensuring that all Floridians will have health care coverage by the end of 1994. If significant improvements are not made voluntarily, I will propose greater market and structural reforms to ensure global health care access.

I feel confident that the people of my state support my vision. I will, however, need your help to fully implement our plan. Health care is an area in which the states and the federal government must cooperate closely to achieve change.

Laboratories of Democracy

My friend David Osborne, who wrote Laboratories of Democracy (1990), was inspired by an often-quoted comment in a dissenting opinion by Supreme Court Justice Louis Brandeis:

> There must be power in the States and the Nation to remould, through experimentation, our economic practices and institutions to meet changing social and economic needs...Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.

The states are finding it difficult to serve as laboratories, particularly in the area of health care policy, because it is subject to many strict and unyielding federal laws and regulations. Several states, including Florida, Massachusetts, Minnesota, New York, Oregon, and Washington, have proposed major health care reforms to insure all their citizens. They are willing to serve as the nation's health care laboratories, but virtually all these pathfinders have been soundly criticized, and many of their reforms have been weakened or eliminated in an effort to make them conform to federal requirements. I share the fear of Christopher Atchinson, Director of the Iowa Department of Public Health:

> States have the opportunity to become laboratories for experimentation, leading to a solution to this most difficult issue (health care). I don't want our laboratory to be underdeveloped and overregulated (National Governors' Association, 1991).

Franklin Roosevelt once said that "practically all the things we've done in the federal government are like things Al Smith did as governor of New York," underscoring that many of the New Deal social programs, including Social Security and unemployment compensation, were modeled on successful state programs (Osborne, 1990). The widespread retreat from federalism and greater use of preemption prevents the federal government from capitalizing on this proven approach for experimenting with social and health reforms.

The 1960s' War on Poverty included a massive federal investment in new health care programs for the elderly and the poor, community health centers, and public health funding. Although the Medicare Program has been a successful mechanism for ensuring health services for the nation's elderly, its beneficiaries are paying an increasing percentage of their health care costs out-of-pocket. The Medicaid Program has helped the states pay for the medical care of low-income families and supplement the coverages of elderly and disabled persons, however, it now only covers 40 percent of the nation's population with below poverty incomes.

The 1970s was a period of rapid technological advancement, continued investment in the nation's health care infrastructure, changes in the commercial health insurance market, growth in employer self-funding, and staggering increases in health care expenditures. For fiscal and ideological reasons, the 1980s was a period of retrenchment. Spending limits, debt and entitlement costs have forced the federal government to slash block grants, eliminate federal programs, and try to accomplish its social agenda through state mandates, particularly in the area of Medicaid. Greater responsibility for health programming was shifted to the states (Fox and Schaffer, 1989). In the 1990s, the states are aggressively carrying out these responsibilities, expanding coverages, reforming insurance practices, controlling provider costs, and testing various managed care strategies.

The states are now proposing more fundamental reforms to insure all their citizens and reduce costs through the use of alternative payer methods. Many of these reforms will require federal approval and financial support. Unfortunately, even in the absence of national reforms, the federal response has been outdated and cumbersome program regulatory requirements, delays

and inaction on state waiver proposals, costly federal mandates, troublesome audit and disallowance practices, and delays in rulemaking.

Mr. Chairman, I concur with your comments in October when you said that:

> **Many states and local communities have been pushed to the brink of economic disaster due to health care expenditures that still allow far too many to fall between the cracks in our tattered safety net. State and federal governments have often failed to assess realistically the factors fueling this crisis and to enact responsible reforms...states clearly find themselves between a rock and a hard place. They have been required to provide more services to more people--without the federal government assuring that the states will have the resources needed for these and other crucial social programs that affect health.**

Florida, like other states, is suffering through what is possibly its worst recession since the Great Depression. The recession has resulted in sharp reductions in revenues and massive governmental funding cutbacks, despite increased demands for services. But the economic downturn has increased

my enthusiasm for capitalizing on our opportunities. We face new challenges to be more productive and efficient, to find better ways to do things, and to increase public confidence in government and the integrity of its officials.

Federal Statutory and Regulatory Reforms

I am optimistic about our chances of enacting major health care reforms in the near term. Meaningful changes, however, require a partnership of the federal and state governments. The states are ready to promise accountability in exchange for flexibility. This compact will permit us to fully test the health care innovations that will serve as the basis for national reforms.

The Bush Administration's FY 1993 budget proposal sets a cooperative tone when it asserts that:

> Innovation at the State level can address the problems of rising medical expenditures and access to quality health care....The Administration will continue to encourage States to test new and creative ideas and provide incentives to experiment with new initiatives, by allowing states flexibility that is not available under current law.

In the same spirit, the 1986 Advisory Commission on Intergovernmental Relations adopted several principles intended to renew federalism, guide federal regulatory decisions, and eliminate the federal government's micromanagement of state and local governments. These principles are worth reviewing to assess the negative impact of federal regulation on the potential success of health care reforms (Daniels and Dimitrief, 1987):

- In most areas of governmental concern, state and local governments uniquely possess the constitutional authority, the resources, and the competence to discern the sentiments of the people and govern accordingly.
- The nature of our constitutional system encourages a healthy diversity in the public policies adopted by the people of the several states to their own conditions and needs, and frees them to experiment with a variety of approaches to public issues.
- Policies of the national government should recognize the responsibility of--and should encourage opportunities for--individuals, families, neighborhoods, local governments and private associations to achieve their personal, social, and economic objectives through cooperative efforts.

David Osborne has described the new breed of governors, fully supportive of federalism, who are now designing the public/private partnerships needed to solve major social and economic issues. They are either fighting or coalescing special interests to get important legislation adopted on contentious social issues. There is rarely a consensus among health care providers, insurers, businesses, and consumers on major health care problems. But Florida, like a few other states, has been able to overcome the odds and adopt major structural reforms to its health care system. The states able to achieve this almost impossible task are now having some of their reforms blocked at the federal level.

In the past, the states negotiated their health care proposals individually with the federal government. The state of Minnesota petitioned Congress in 1988 to "obtain a limited exemption from the ERISA provisions that prohibit the states from regulating employment-based health benefits directly, so that the state could establish requirements or tax incentives directly affecting employers and employment-based health benefits that are intended to protect consumers, ensure adequate coverage, promote access to coverage, or promote competition" (134 Congressional Record S 5,241, 4/29/88). Oregon has met steep resistance to its benefit design strategies. Innovative proposals from other states, including California and Washington, also require federal statutory changes and regulatory waivers to proceed. National health care reform proposals, including Senator Mitchell's HealthAmerica plan and your own National Health Insurance Act, also include innovations that would require similar statutory and regulatory changes.

There is an emerging pattern here. As more and more health care reform proposals are presented, you will begin to hear repeated requests for similar statutory changes and regulatory waivers from individual states, as well as advocates of national reform. If any of us are to succeed as laboratories of democracy, we must be given the tools to experiment.

Recognizing that states are facing the same problems and seeking similar solutions, the National Governors' Association adopted the position that states should be granted the flexibility needed to implement bold structural changes to the health care system. The federal government must work with the states to accelerate comprehensive, statewide approaches to expanding access and containing costs (National Governors' Association, 1991).

To fully test the state's health care reforms, Florida needs statutory changes and regulatory waivers in the areas of Medicaid, the Employment Retirement Income Security Act of 1974 (ERISA), Medicare, and other health legislative areas. I will briefly discuss needed changes in each area.

Medicaid

I would like to talk about Medicaid "waivers" in both the generic and the specific sense. That is, I would like first to talk about three needed changes to the Medicaid statute so that it matches what most people think it is--assistance to the states to pay for health care for the poor--and then talk about other technical changes to the current program.

First, we need a statutory change to permit federal funding to the states to cover not only the categorical eligible, but others with incomes at a higher percentage of poverty. In addition, we should dispense with our present complex eligibility tests for this group in lieu of faster and simpler means such as pay stubs and income tax returns. Not all states could take advantage of this assistance, and premium cost-sharing by the recipient should be required. However, without federal assistance to help pay for the large group of uninsured people with incomes above current Medicaid levels, state governments cannot reasonably be expected to shoulder the financial burden alone. Nor does the prospect of fully insuring our citizens at an affordable, non-subsidized price seem a realistic alternative.

Second, we should rethink the nature of assistance to the states to purchase health insurance for low-income citizens. That is, it need not be entirely entitlement driven. Florida is proposing a Medicaid Buy-In program that would offer a basic, low-cost plan targeted at people with lower incomes and small businesses. Even without a premium subsidy, it would be helpful to have a federal partner to back the risk of adverse experience at Medicaid financial participation rates. Today, if we attempt such a program, we are completely at risk, even though we are trying to solve a shared federal and state problem. The same is true for "high risk" health insurance pools with which our state and others have experimented.

Third, as this recession has once again shown, when times are bad, welfare and Medicaid rolls increase at the same time state revenues decrease. The result is a gut-wrenching reduction in services and eligibility at the very moment that need is on the rise. Unlike the federal government, the states do not have the ability to cushion economic downturns. What is needed is significantly enhanced federal Medicaid matching funds during economic downturns--be they regional or national in nature.

Now let me turn to some specific areas in which the states need regulatory relief.

First, we need relief from the often picayune nature of federal audits and disallowances in the Medicaid program. These audits cost the states millions of dollars, do not involve any serious allegations of harm to patients, and seriously jeopardize a harmonious federal-state relationship. For instance, my state recently lost $7 million in federal funds because licensing inspectors signed ICF/MR certification forms 3 to 9 days late. The inspection had been completed in a timely fashion, and no threat to life or safety was found. Nonetheless, all federal expenditures were disallowed, and the Federal Grant Appeals Board was not permitted to take these circumstances into account. I recommend to you Senate Bill 1240 (Chaffee and Riegle), which would remedy these problems and promote better federal and state harmony.

Second, our ability to launch cost containment initiatives is severely impeded by current federal "freedom of choice" and HMO requirements. While HCFA has done much in the last year to streamline these requirements, emulation of private sector cost containment initiatives is extremely difficult in the Medicaid program due to these requirements. For instance, the current "75/25" rule with regard to Medicaid HMOs has outlived its usefulness, and this statute should be repealed. HMOs show much promise for public and private patients alike. Where entities, particularly public hospitals and local health departments, have organized health care for Medicaid recipients in a better way, we do not believe they should be terminated from the program (or forced through interminable bureaucratic hoops) simply because they do not enroll private patients. We believe the issue is quality, not the proportion of enrollments a payer funds.

Third, there are a host of technical issues that need remedy in the areas of demonstrations, freedom of choice and home and community-based waivers in the Medicaid program. In the area of demonstrations, for example, it literally requires "an act of Congress" to extend these programs beyond three years. For states who are trying to revolutionize their health systems, and incurring all the political and economic unrest associated with such a change, this is a discouraging factor. Not only is the time too short, but also the potential pitfalls of assuring that Congress will continue the program are great, making use of this waiver authority risky business at best. What if the program is started, goes through growing pains, and then Congressional approval is not obtained?

Some of the home and community-based and freedom of choice waivers demonstrate the problems with the current statutory setup. For instance, freedom of choice waivers must be evaluated at the time of submission of the renewal waiver (two years). However, the waiver request (and evaluation) must be submitted at least three months prior to renewal, and time must be allowed for startup (about six months), and for data collection and analysis (three months). In addition, claims data are usually available only three months after services have been provided (due to slow claims filing by providers). This means that at best, nine month's worth of data can be analyzed prior to renewal--frequently too short a time to permit a valid analysis. The result, whether a waiver renewal or denial, is that judgments are made on skimpy data. To add insult to injury, these evaluations are required to be continued--technically every two years--for as long as the program is successful and is renewed by the state. This wastes a lot of our resources.

Fourth, we need to rethink several federal Medicaid requirements visited by federal law onto the states. One of the most important is the "Boren amendment," which is being interpreted by the courts as a mandated return to cost-based institutional reimbursement. This is the very thing the Boren amendment was designed to correct, by permitting experimentation with prospective and other forms of reimbursement. Still another problem is the requirement that all drugs be covered for which there is a federal rebate agreement, without restriction, for the first six months of market entry. The list goes on and on.

The important point is that we need to rethink this entire Medicaid statute if we are going to let states have the flexibility to cost-effectively purchase health care for our citizens. After all, the federal government gets a larger share of the savings than the states. What we want to do is reinvest that savings by spending it on care for people who are not covered today.

Fifth and finally, we need to rethink federal policy in the area of the "Qualified Medicare Beneficiary," also known as the QMB. This well-intentioned federal policy, stemming from what little is left of the Medicare Catastrophic Act of 1988, is posing a large administrative and expenditure burden on the states. In our state, we are required to pay premiums, co-insurance and deductibles for people who, in addition to having the benefit of Medicare insurance, by 1994 will have incomes up to 120 percent of poverty. In 1989 and 1990 Florida spent $20 million more on Part A premiums than it would have spent simply by paying for care outright.

Medicare

In addition to Medicaid changes, I am asking that Congress explore the state-by-state administration of Medicare payments and the implementation of managed care for Medicare beneficiaries. In enacting the Medicare and Medicaid programs, Congress decided to establish a federally administered health program for the elderly and some disabled persons, but a state administered program of medical assistance for low-income families and other disabled and long-term care patients. There is no inherent reason that administration of these programs should continue in this way. In fact, the continuation of this peculiar administrative split impairs state-level health care reform planning.

In many respects, Medicaid is becoming a supplemental insurance program for low-income or institutionalized Medicare beneficiaries. But the states do not have the discretion to merge their Medicare supplemental coverages with the federal Medicare Program. The result has been a lack of coordinated coverages for the nation's elderly. The states are unable to maximize the value of Medicare investments by broadening long-term care coverages to include home and community-based services.

In Florida, health reforms for elders have lagged behind innovations for families and children because of federal Medicare administration. States are more knowledgeable of their populations and health care systems than the federal government is, but their unique ability to plan programs for Medicare beneficiaries that provide greater levels of services at less cost is hampered by rigid, uniform regulation.

Section 402 of the Social Security Amendments of 1967 (P.L. 90-248) authorized the Secretary of the Department of Health and Human Services to conduct demonstration projects to determine the effectiveness of health care reimbursement systems established under state law. The Health Care Financing Administration has supported a variety of Medicare and Medicaid prospective reimbursement and rate setting programs administered by several states. The most notable experiments were the all-payer reimbursement systems authorized in Maryland, Massachusetts, New Jersey, and New York. When Medicare began to participate in these reimbursement demonstrations, there was little data on the success of alternative reimbursement methods. Later they narrowed their demonstration interests to diagnosis-related units of payment that eventually led to the creation of the successful Medicare Prospective Payment System.

A similar rationale now exists for Medicare and Medicaid demonstrations of single payer systems. They could very well be the next major health care cost containment tool. State experiments of single payer systems, assuming other ERISA and antitrust waivers, should include the federal Medicare Program. With its large elderly population that accounts for more than 60 percent of hospital expenditures, Florida would be an ideal site to test a congressionally authorized single payer system.

Medicare has fallen behind the states in experimenting with managed care and utilization control programs. I believe Medicare needs to further test alternative case management strategies for the same reasons it tested alternative reimbursement systems in the 1970s and 1980s. To capitalize on state managed care and utilization control systems, Congress should authorize state managed care demonstrations to learn how to better control Medicare beneficiaries' use of services, improve the quality of needed care, and decrease per capita costs.

For these reasons, I recommend that Medicare laws be amended to permit wide-scale demonstrations of alternative payer systems and Medicare beneficiary managed care programs. Section 1886(c) of the Social Security Act, as added by the Tax Equity and Fiscal Responsibility Act of 1982, permits the HHS Secretary to waive ordinary methods of Medicare payment and permit experimental state cost control systems with respect to hospital reimbursement. This provision could be amended to authorize HHS to conduct experimental, state administered cost control and managed care systems, including state administration of all Medicare benefits through single payer systems.

ERISA

Since three out of four uninsured Floridians are either employed or dependents of employed people, there is no doubt that Florida's plans for an employer-based full access health care system will require several key private health insurance reforms to succeed. My reform plan, which preserves a role for commercial insurance and self-insuring employers, cannot be fully implemented because of the Employee Retirement Income Security Act (ERISA). Though private employer-based coverage is the number one source of health insurance for most Floridians, spiraling premium costs have placed these policies out of reach for most small or medium-sized businesses and their workers. The gradual failure of the private health insurance industry to serve the small business market in an affordable manner is one of the primary reasons we have developed the Florida Health Plan.

In the past two sessions, the Florida Legislature has enacted major private health insurance reforms. However, the state cannot enact the additional reforms needed to equitably spread risk across all groups, guarantee a minimum level of coverage, or install managed care or alternative payer systems because of ERISA preemption of state regulation. Skeptics of such reforms contend that only a government operated universal health care program will achieve the systemic changes Americans are demanding. Practically and philosophically, however, I favor continuation of the employer-based system. I believe it is a system that Americans generally favor and want to preserve.

The Florida Health Plan will initially try to achieve health care coverage for all Floridians by relying primarily on employers. Employer responsibility for providing health insurance coverage for full-time workers and their dependents will be voluntary for a period of two and one-half years. But this plan represents more than a business-as-usual approach to the problem. We will begin setting targets that challenge our business community to make a commitment to expand health insurance on a voluntary basis. If substantial progress is being made towards covering all Floridians by the end of 1994, I will recommend continuation of the voluntary approach. But if this proves ineffective, I will propose more fundamental reforms, possibly including a "play or pay" mechanism, in which employers would have the choice of either providing insurance benefits directly or paying into a public fund for their employees' coverage.

In today's private multi-payer system, it has not been possible to limit overall health care spending with payments and reimbursements flowing from so many sources. In addition to Medicare and Medicaid, 770 private individual carriers write health insurance policies in Florida. (Florida House of Representatives, 1991) This multi-payer system exerts little control over health care costs. We know that health care costs are skyrocketing and that care is unavailable to millions of our citizens. Therefore, we need to develop strategies to slow the runaway cost of health care. Unfortunately, the problems of the employer-based, private health insurance system will become worse if states are not given additional powers to regulate the system.

In 1974, the 93rd Congress enacted the Employee Retirement Income Security Act. Congress determined that the national interest required legislation to protect employee benefits. It also determined, because of growth in the size, scope, and numbers of employee benefit plans, that their operational scope and economic impact is increasingly interstate, that the continued well-being and security of millions of employees and their dependents is directly affected by these plans, and that interstate commerce must be protected by preempting state regulation of employee benefit plans (P.L. 93-406).

Since then, a coalition of groups, including labor, business, and insurers, have become a powerful force against any modification of the ERISA semi-preemption clause. In fact, extension of the preemption to commercial insurance has been proposed. Fox and Schaffer's analysis of legislative materials and interviews with key legislators and lobbyists demonstrate that labor and interstate employers wanted to prevent three things: (1) state regulation of health and pension plans negotiated by management and labor, (2) state interference in collective bargaining, and (3) state taxation of premiums. They also wanted to ensure uniformity of regulation of national contracts and the freedom to exchange benefits for cash wages or one benefit for another (Fox and Schaffer, 1989). Only a few amendments since 1974 have successfully run the gauntlet of special interests: (1) the exemption of Hawaii's Prepaid Health Care Act, (2) the authorization of state regulation of multiple employer trusts, and (3) the mandate for states to require insurers to make Medicaid a secondary payer (Fox and Schaffer, 1989).

ERISA has been construed by the courts as having an extremely broad preemptive effect with little room for state involvement, with the possible exception of the regulation of benefits (as opposed to benefit plans) and of self-insuring employers who use a third party administrator to manage plan benefits (Ballam, 1989). Legal analyses of the states' ability to make major structural health care reforms under ERISA are bleak. Only a decision authored by Supreme Court Justice Arthur Kennedy when he was a judge with the 9th Circuit Court offers any promise. He concluded that self-insuring employers who purchase stop-loss insurance, as most do, are subject to state regulation (Fox and Schaffer, 1989).

ERISA has had major effects on the nation's health policies and is now delaying the further development of important health care reforms. Although the original purposes of Section 514 may still be worthy, continuing to preclude state regulation of self-funded plans will come at a great expense:

- States may move ahead with health reforms, risking a likely ERISA challenge that could delay implementation for years. Massachusetts passed a law taxing employers to fund health insurance benefits for the uninsured. Tax proceeds would be rebated dollar-for-dollar for health premium expenditures. This provision is currently being litigated. Others may attempt to capitalize on judicial decisions that seem to permit regulation of self-funded employer plans if they do not impose an undue administrative burden on the self-insurer, purchase stop-loss insurance, or are administered by a third party (Fox and Schaffer, 1988; Fox and Schaffer, 1989; Ballam 1989, Firfer, 1990).

- States may be immobilized, stuck at the proposal stage, fearing litigation and interminable delays, but unwilling either to implement minor incremental changes or more radical changes.

- States may abandon the employer-based and private insurance system that Americans prefer and implement universal programs modeled on the Canadian system that sidestep ERISA preemption.

- Fearing employer mandates, businesses may rush to self-insure, further eroding state regulation of health insurance and preventing the universal sharing of risk that is essential to most major health care reform proposals.

Although not fatal to my plan, failure to achieve ERISA reforms will prevent the implementation of key parts. It will prevent Florida from regulating self-funded employee benefits or benefit plans, mandating employer insurance, or possibly affect any employer tax to finance health reforms. I understand that forsaking ERISA protections would be a difficult decision, and alternatives would be exceedingly difficult to draft because of so many special interests in legislative protections.

More than 50 percent of Florida's covered workers are employed by self-insuring firms. Failure to secure changes in ERISA will result in (1) an uneven playing field between commercial insurers and self-funded plans; (2) continued cost shifts to larger self-funded plans because smaller employers cannot afford commercial insurance; (3) possible abandonment of the employer-based and private insurance system; and (4) the possible erosion of benefits for employees in unregulated self-funded plans. There are several possibilities for solving the states' dilemma and providing relief from ERISA's stringent standards:

- Establish national benefit standards, employer insurance requirements, and a uniform system of regulation by modifying ERISA or amending other statutes (e.g., Internal Revenue Code, Social Security Act, Public Health

Service Act) to regulate both insured and self-insured plans (Committee on Ways and Means, U.S. House of Representatives, 1990).

- Simply repeal the ERISA preemption clause, allowing the states to fully regulate health insurance, including self-funding plans; this will permit states to regulate all insurers equally.
- Alternatively, repeal ERISA preemption for all benefit plans except those that are negotiated by interstate employers or by national unions, requiring the states to permit interstate benefit plans to show equivalency to mandated benefits.
- Repeal the ERISA preemption clause for states that ensure basic benefit coverage for all citizens.
- Allow the Secretary of the Department of Labor to waive statutory requirements to test ERISA-prohibited reforms, such as employer mandates and single payer systems.
- Authorize state-specific state health reform demonstrations in federal statute.
- Limit ERISA protections to currently self-funded plans, preventing employers not currently insuring their employees from fleeing to ERISA

protection by self-insuring when states impose mandates or other regulatory reforms on non-ERISA protected insurers.

- Amend ERISA to permit states to spread the risk of high-cost cases to all insurers, commercial or self-funded.

I recommend that Congress schedule testimony as soon as possible to draft ERISA revisions that balance the special interests of labor, business, and insurers with those of states confronted by rising health care costs and increasing uninsurance rates.

I would like to add that I fully support private sector efforts to solve our health care cost and access problems, but I am also aware of the depth of these problems, and the extreme difficulty we as a nation have had in attempting to solve them. If private efforts alone could provide access for all citizens to health care at a reasonable price, I believe they would already have done so. A real solution to our growing health care dilemma will require a public-private partnership and a cooperative effort by all concerned.

Other Regulatory Issues

I would like to commend Congress on its recent history of enacting stronger federal certification standards for the nation's health care facilities. In particular, the OBRA 87 requirements have led to better care in our state's long-term care facilities. The number of nursing home residents who are physically restrained has dropped from 55 percent in 1987 to 17 percent in 1992. In addition, the COBRA hospital emergency access provisions, which parallel Florida's state licensure requirements, have strengthened our position in forcing hospital compliance and ensuring proper handling of emergency room patients.

Florida, however, takes issue with some federal quality of care regulatory requirements. First, Florida is opposed to further privatization of the certification process. HCFA currently allows hospitals accredited by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) to substitute JCAHO accreditations for federal certification surveys. I understand that HCFA is studying the feasibility of deeming private accreditations obtained by other health care facilities for Medicare and Medicaid certification purposes. I believe that regulation of quality of care is a public health responsibility that cannot be delegated to the private sector. Private assessments are more costly, provide for less public disclosure of findings, and are less stringent. If this function is delegated, the surveys conducted by private accreditation organizations should at least conform to federal standards.

In addition, I believe that HCFA has focused on the certification standards for long-term care institutions, home health agencies, and clinical laboratories, giving less attention to the quality of care improvements needed in other health care facilities. I recommend that a more balanced regulatory process be adopted in which HCFA attends to the quality of care requirements of all health care facilities subject to Medicare and Medicaid certification.

My state agencies are also concerned about the time elapsing between legislation and draft regulations and between draft and final regulations, as evidenced by the time needed to conclude OBRA 87 and CLIA rulemaking. Implementation delays make it difficult for the states to determine future resource requirements, or to work with health care providers to ensure a smooth transition to new standards.

I believe that Congress should authorize state "equivalency," allowing the states to substitute their licensure standards for similar federal standards. I also support federal matching funds for innovative state licensure programs that are outcome oriented, lead to superior care, and contain health care costs. Finally, I believe that Congress and HCFA should be ever mindful that overregulation is expensive and simply drives up costs, making insurance less affordable. Detailed fiscal impacts, using estimates from the states, should be prepared to assess the cost implications of new federal regulatory standards.

CLOSING REMARKS

Heavy federal regulation of the states' health care systems, including Medicare, Medicaid, and ERISA dictates, has stressed uniformity over experimentation. However, uniformity is more desirable in some areas than in others (e.g., currency). It is also more desirable when there is a consensus about what should be done. Until the imposition of a national health insurance program, states should not be prohibited from taking different approaches to common problems. Uniformity is simply a euphemism for the disablement of state authority (Wolfson, 1988). This suggests a final option that I would like to mention.

Because of the overriding importance of testing alternative structural health care reforms in anticipation of national preemption through a national health care program or a highly federally regulated state-administered health program, Congress could legislate a new section of the Social Security Act, authorizing large-scale demonstrations of health care reform plans. This could include generalized authority for waiving Medicaid, Medicare, ERISA, federal antitrust laws (needed for implementation of a single payer system), and any other statutes or regulations necessary to obtain a full test of an innovative health care reform plan involving multiple federal programs.

Correcting the inadequacies of my state's health care system and securing sufficient revenues to fund essential public services are two of my biggest challenges as governor. Florida's problems, although unique in some respects, are similar to those faced by all governors, Congress, and the President. Major health care reform is now at the forefront of public debate. Although a Bush Administration proposal and several congressional bills propose to redesign our complex health care system, there is no assurance that Congress and the Administration will agree on health care reforms in the near future. The year of a presidential election is not a time when party differences will be laid aside easily, but our citizens demand and deserve a bipartisan approach to health reform. Now is the time for leadership and statesmanship. The longer we delay, the more our options narrow. We have long passed the point that minor tinkering will solve the problem. We have no choice but to act boldly.

Perhaps it is also necessary to acknowledge that many of the important players in the health care industry benefit economically under the current system. Under these circumstances, we would naturally expect that those who are doing well may be reluctant to advocate change. But we question how long this state of affairs can continue. When we hear it said that the United States has the best health care in the world, we must remind ourselves that it is only the best for the people who have access to it. We cannot continue to ignore the millions without coverage.

Our people have spoken; they want government to ensure health care for all. There is neither an easy solution, nor a single solution, and many difficult steps must be taken to recast our health care system into one that is effective, economical, and available to all. My job and yours is to aggressively tackle the remaining problems and find the path to true health care reform. Further delay is no longer acceptable to the people. I am convinced that the solution lies in granting the states the additional flexibility they need to test their innovative health reform plans.

Mr. Dingell. Governor, the committee thanks you both for your presence and for your very valuable testimony and statement. I feel particularly pleased to see an old friend back before us.

The Chair is going to recognize now my colleagues, starting with Dr. Rowland.

Mr. Rowland. Thank you, Mr. Chairman. Thank you very much, Governor Chiles, for your comments.

Let me ask you a little bit about the Medicaid buy-in that you propose there. I think that one of the most difficult problems that we have in trying to basically restructure our health care delivery system is a mechanism to finance it. That's not just true for this country. I have visited several Western European countries. I have been to Canada. All of them are having increasing difficulty, the governments are having increasing difficulty in finding ways to finance the increasing demands on those systems and they are struggling to do that.

It seems to me that the Medicaid program has been one that is subject to great abuse by recipients as well as providers of care, and while it has brought care to the poor and has helped improve their situation significantly, it has cost far more than was ever anticipated at the time of its inception.

What types of cost containment measures have you thought about if there is a buy-in into the Medicaid program? How will those abuses that have occurred be controlled?

Governor Chiles. I think there may be several ways. One, we are, in our health reform act that we have passed, we have combined really sort of all of our leverage into one department and so many areas, many times it's like you are building a new bureaucracy. We're taking kind of what is out there and putting it together.

Our cost containment board will reside at the same place where we in effect, in the same area, in the same department where we have control over physicians, where we have control over in effect the hospitals and the medical care providers who are, you see, bringing them all in together.

We in Florida have an aggressive fraud detection unit and we are making some pretty strong cases and we have certainly had some problems in Florida, as this committee knows, but we are now aggressively pursuing, and we run a profile that we pretty well can tell if, you know, some problems are out there or where we should look if we see certain things start showing up on that profile. It's like the IRS does on our tax returns, the way they screen them.

That's been very helpful to us. I think that is something that can be done and as I say we are going much further towards cost containment. We are going to direct and manage care. We are doing things like allowing physicians that participate in Medicaid to perhaps have some of the State's sovereign immunity so not be subject to some of the malpractice claims. That's a hammer and a carrot, you know, as you go into that, so we are taking a number of steps to do that and I would say we are administering a Medicaid program in a pretty efficient way but we intend to build it up even stronger in our detection methods.

Mr. **Rowland**. You've been working with the Florida Medical Association——

Governor **Chiles**. Yes, sir. Oh, another thing I wanted to tell you, part of the legislation we passed will prohibit physician-owned clinics being able to refer and I think we're landmark legislation in that regard. We have given them a couple of years to just terminate those clinics and so you will not have physicians referring patients to clinics, to labs in which—or other facilities that they have an interest in.

Mr. **Rowland**. You have been working with the Florida Medical Association, I assume, in putting this together.

Governor **Chiles**. Yes.

Mr. **Rowland**. And do you have a good reception from them——

Governor **Chiles**. Yes, sir.

Mr. **Rowland**. Do you have a good reception insofar as the cost containment fees? Are they receptive to accepting——

Governor **Chiles**. Well, yes they are. They were very supportive of our legislation, but understand, what our legislation has done is really said we are going to give the doctors, the insurance providers, the business community, everybody a period of time to accomplish this coverage on a voluntary basis.

While that is going on, we are putting together a board that will determine what additional steps be taken and as of December of 1994, if we have not covered people, we will be ready to move forward with pay-or-play or other mandatory provisions, so what the Medical Society and all of the groups have bought in to the concept, you know, that we have drawn the line in the sand. It's got to be done by 1994 and so in effect we have sort of set the dimensions of the playing field.

Now there are going to be some knock-down, drag-outs between now and then as to how—as we get there, but everybody has bought in at this stage that we are going to get it done, that they have to participate, and so——

Mr. **Rowland**. Where is your principal opposition to this proposal? Trial lawyers I am sure are going to be opposed to some immunity——

Governor **Chiles**. Well, the trial lawyers were very opposed to a general immunity.

Basically as we have restricted it, you know, to the work on Medicaid patients, they have—you know, part of that opposition has changed.

Generally speaking, I think to start with everyone had wanted something different but I think they began to realize that Florida was serious, that we were going to go in this direction, that we were going to give a period of time to see if it could be done—in other words, we called their bluff, basically, to all of the groups that say the private sector can do this, we can do a voluntary thing. We said fine; we'll give you till December of 1994 to do it and we'll put all of these steps in place to help and that's community rating.

You know, one of the big problems is where a small business gets rated totally different or if a small business has one person with a disease or has had a pre-existing disease it blows them out of the water, so community rating, pool-buying, all of these are steps that we think will help take part of that 2½ million out. The Medicaid buy-in is a big step to take a portion of the 2½ million out.

We think that with the combination of those things we really think it is possible to get there, but if we don't for that piece that's left, again, everybody knows that we are going forward with something mandatory.

Mr. ROWLAND. This buy-in would be indexed?

Governor CHILES. Yes, sir. See, what we would be asking is that we be able to go above the poverty rate.

Now, this would cost the Federal Government some money, but we would match it with State, 55 to 45. We estimate, for $1 billion, the Federal Government, matched by about $850 million from the State, that we could cover this 2½ million people.

Now, when you look at what it cost the Federal Government from last year to this year in the increase in the Medicaid cost, that was $600 million. So, the president and certain people say this has to be cost effective.

Hell, we can almost assure it is cost effective in the first year, because—and again, if you subscribe to the theory which I so strongly do, until you provide access to everyone, you cannot control costs.

I used to think you had to control costs before you provided access. Now it's clear that people get health care. They go to the emergency room. They wait until they are so sick, and they get their care in a way that is much more expensive.

So, until we provide that family doctor for them, we will not be able to manage, you know, the health care, and of course, we are trying to get away from fee for service and go to managed care. All of those things are part of what we are trying to do.

Mr. ROWLAND. The funding will be principally Federal and State.

Governor CHILES. Yes.

Mr. ROWLAND. Has any thought been given——

Governor CHILES. No. We anticipate that, from the private sector, again because of the hammer that we have got, that we are going to have much more participation, some from the private sector, as well.

Mr. ROWLAND. The private sector as well?

Governor CHILES. Yes, sir.

Mr. ROWLAND. What about local government, county and city government? Has any thought been given to involving them as well?

Governor CHILES. Well, in Florida, I might say, we have just passed a reorganization of our health delivery service which decentralizes it and brings it back under local control. We think that is very much going to make a partner of the local county and city government in all of these steps that we are taking.

Mr. ROWLAND. So, you are looking at Florida as being a demonstration project——

Governor CHILES. Yes, sir.

Mr. ROWLAND [continuing]. To see how this would work.

Governor CHILES. Yes, sir.

Mr. ROWLAND. You are not aware of any other State having a similar proposal.

Governor CHILES. Well, let me tell how we would differ, sort of, from the Oregon proposal, maybe.

Oregon decided how many dollars they had to spend and then, in effect, built their benefit package based on the dollars they had to spend.

We are trying to reverse that and say we want to build a basic benefit package based on need, what we think, really, a family should have and then we will put together the dollars to take care of that need.

So, I would say Oregon is trying to do what we are doing. Hawaii, with their sort of single plan, is trying to do that, as well.

I think 4 or 5 ought to experiment, maybe up to 10, and let us see what works out there.

Mr. ROWLAND. I see my time has expired.

Mr. Chairman, I hope we come back for another round of questions.

Mr. DINGELL. It is the Chair's plan to hear from the Governor in any way he wants and to allow the members to explore these questions with him as fully as possible.

Mr. ROWLAND. Thank you.

Mr. DINGELL. The gentleman from Florida, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Just, I guess, a generic question but a very significant one, Governor. You have been talking about the Florida plan with Congressman Rowland. I am sure you know that some sort of a national health plan, whatever the title might ultimately be, is on a relatively fast track up here.

I do not think any of us anticipate anything like that in the year 1992, but hearings are already being held. I am not sure if any markups will be held, but in any case, we do not expect anything on the floor this year, but it is on a fast track.

Now, you basically used the term "the solution" or something to that effect, and I do not mean to pit your ideas or our parochial Florida ideas against the Federal Government or against the Congress, but might you be suggesting that it would be best if the Federal Government passed laws, and addressed the question of flexibility and waivers and the use of the Medicare dollars and then leaving it up to the States, encouraging the States somehow to pass their own particular plans, rather than a national plan?

Governor CHILES. Well, we need the Federal Government as a partner to ultimately take care of this problem. I am not going to tell you that we can totally do it on our own, but I guess there are two points I want to make.

One, if the Federal Government passed a national plan today, I would hope that would not be in the old mode that we used to do things that was top-down, that told every State exactly what they had to do and how they had to do it, and the old way that we did things, because that is where I think we get a lot of the problems.

States are unique. They have different problems. They have different capabilities.

Something that, again, provided outcome measures that the States had to comply with, the States having to come up with a plan that would pass muster of certain requirements, all of that, I think, would be good. The Federal Government needs to follow its dollars.

It needs to be able to monitor and audit its dollars and should not just pass the money down, but the more specificity there is in the national plan of locking it in, the more problems we will have of ever making that work, because again, it has to be administered line by line, with all kind of personnel, and the bureaucracy gets into it, and then any change would go back into a waiver process and all.

So, the more flexible it could be, the more goal oriented, the more outcome measured that it could be, it would be better.

Now, what we are saying is—and you said relatively fast track. These cases that I am talking about are occurring in Florida today, and they have been, and we cannot wait or we should not be waiting.

So, we are saying, in effect, even if it was the same amount of dollars, but we would like to ask for a little bit more for the buy-in that I have talked about, free us up and let us demonstrate, you know, some of the things that work that would again, I think, give the ability to draw the better national plan so it would show why it needs the flexibility, why it needs those things, and the other thing is, politically, as we are talking, nothing is going to happen this year.

If something like the Leahy bill passed or a similar bill that is on the House side that gave some States sort of blanket waivers, I think that would be the best thing that could possibly happen.

Mr. BILIRAKIS. Well, you have been up here long enough to know that probably anything that we would do would have strings attached and the specificity that you would not like from the standpoint of the States.

Governor CHILES. Well, for the mere thing that we are asking about and the chairman has responded so favorably that you are going to try to do something to give us these waivers, the reason we need these waivers to start with is because the way that the old plan of Medicaid and Medicare is drawn so tight that something comes along, like AIDS, we never anticipated before—now, we are determining, in Florida, we have the lowest percentage of our population that goes into nursing homes of any State in the Nation. Thank goodness we do, because we have the highest percentage of elderly.

The reason we have that is because we work very hard with home health care, with home services, and we need all of the waivers we can get to say let us use part of the nursing care dollars to keep those people at home, where we do it for a tenth of the cost and give them a quality of life that is much better.

So, all of that dictates that you do not want to draw this next national health care bill in the same way we used to do things.

Mr. BILIRAKIS. Thank you, Governor.

Mr. Chairman, I guess, in the process of any sort of a national plan that we come up with, we will have to obviously have to consider in that formula States like Florida that will have already passed their own plans, and thus far, I do not see that happening up here.

Thanks so much, Lawton. It is always great to see you.

Governor CHILES. Thank you.

Mr. BILIRAKIS. Mr. Chairman, thank you for your courtesy in allowing me to ask my questions.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair is going to make an observation.

This is one of the things on which Mr. Waxman and I are now working, and we do intend to consider States that are innovative, that are trying to lead, giving them an opportunity to go forward in the best way possible in the full expectation that they are going to make a valuable contribution to figuring out how we are going to move this current inefficient, wasteful, and insane system of providing health care toward something which makes better sense from everybody's view.

Governor CHILES. Mr. Chairman, you can go ahead and just speak strongly on it. You do not have to hold back.

Mr. DINGELL. The Chair is going to recognize our friend, Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman.

Governor Chiles, I deeply appreciate your willingness to come this morning and testify on the track record in Florida.

The chairman had some hearings a couple of weeks ago in Detroit, where we talked specifically about trying to get a waiver for a Wayne County project, and I am sure that issue will come up later this morning, when HHS is here to talk a little bit about their waivers and flexibility that they are going to need.

I guess the bottom line that I would like to solicit your advice and thoughts on—I am sure that you are probably aware of President Bush's comprehensive health plan that he came out with earlier this year, and on page 66 of their book, it talks about a key component that, "Most importantly, under current law, States must go through a waiver process to secure Federal approval to establish a coordinated care program. Complex statutory waiver requirements are overly rigid and have blocked a number of initiatives that long have been underway in the private sector."

Would you agree with that statement?

Governor CHILES. Yes, sir.

Mr. UPTON. I looked a little bit at the Oregon plan. Maybe what we are trying to do in Michigan, through Wayne County—flexibility in trying to get some waivers from HCFA seem to be exactly what we ought to be looking at, and your testimony, I think, underscores that thought.

Governor CHILES. Yes, sir, very much so, and the fact that, once that ground has been chartered and you see that a waiver works, why should another State wanting to do the same thing, another county, why should they have to go through the same hoop and hurdle, and why should existing States have to go back every 2 or 3 years to renew their waiver at great expense and great cost?

All of that is just sort of a total waste, and it shows you what this bureaucracy is doing to us.

Mr. UPTON. Now, it is my understanding that the waiver for Florida has yet to be granted. Is that correct?

Governor CHILES. We have some waivers that have been granted, but what we are seeking now is literally sort of four different areas of waivers, and those have not been granted. None of those have been.

Mr. Upton. What have been some of the hoops and hurdles that you have been forced to go through?

Governor Chiles. Well, I mentioned earlier, it took us 28 months to get a waiver to be able to treat AIDS patients at home and have the flexibility of using some of the dollars that we were using treating them in a hospital setting, which cost us much more money, did not give them a quality of life that was appropriate, but it took us 28 months to go through that hurdle.

I am sure other States are out there trying to get some waivers on that now. Why shouldn't we just, say, issue something that says you can use your AIDS money for any person it would be.

The cold bed formula is an interesting way of thinking. I do not know whether you understand that or not, and I am not sure I do, but basically what we did is we said if you had a person that was eligible or could have been in a nursing home and you could show that you remove that person from the nursing home and treated them in a home setting, you could use the money. Now, today, under that formula, you have got to show that you have the bed in the nursing home before.

Now, Florida, every month, has all of these people over 65 and 70 moving into the State. Why do we have to go build the beds in the nursing home to show that we have got the cold bed?

Why can't we say, you know, if that person would be eligible, if they meet the criteria, you can use that money to keep them at home? It is going to save the Federal Government money, it is going to save the State money, and allows those people to have a quality of life.

Now, the hoop we have to go through is, in effect, to show you have a nursing home space that is there that you take someone out of or that you do not use, an empty space. That is crazy.

Mr. Upton. You talked a little bit, in an earlier response to a question, that you compared Florida's plan to Oregon's.

Whereas Oregon may have looked at the money first and then looked at the programs, you have been looking at the need first and then try to put the program back together that way.

I know that Florida has had many of the same budget troubles that the State of Michigan has had, and I know that—and I remember when you called a special session, back, I guess it was last December, to look at where the budget could be cut.

Governor Chiles. We are in another special session now.

Mr. Upton. Are you?

Governor Chiles. Yes, sir.

Mr. Upton. I know that, I think, last December, the session resulted in the termination of the medically-needy program, which scaled back Medicaid assistance for elderly and disabled folks with incomes between 90 and 100 percent of the poverty line.

Obviously, all of your budget decisions are because of very tough choices that you have had to make, but did you make that decision more or less on budgetary grounds?

Governor Chiles. Strictly on budgetary grounds. It is a dumb cut, and we said, you know, at the time that we had to make it, because we had a $600 million shortfall, that it ought to be one of the first things that we address.

In the investment budget that I put before the legislature this time, it is one of the key items that we say it does not make sense to cut that money. When we reached that—see, I have had to cut about $2 billion in the last year.

I said the first billion I do not think will be missed. When we got into the second billion, we began to cut good programs. That was one of the very good programs we had to cut. Now, we cut that one because we cannot cut the Medicaid for the poverty. It was an elective program.

We also cut the program that provided prescription drugs for elderly citizens that keeps them out of nursing homes, again totally wrong, and we say now that is why we need to have some additional income in Florida, because those programs are not savings. They are transferring of cost. They are transferring of suffering. They do not make sense at all.

Mr. Upton. Thank you.

I yield back, Mr. Chairman.

Mr. Dingell. The Chair thanks the gentleman.

Governor, you have talked about the waiver problem, and I would like to ask some questions on that.

First, what happens to the Florida plan if you do not get the waivers that you have requested soon?

Governor Chiles. Well, we go forward as far as we possibly can go.

Mr. Dingell. You will be hamstrung somewhat by the absence of those waivers.

Governor Chiles. Yes, sir. We will not be able to get to our goal in 1994, and we will not be able to mandate some of the coverage that we are talking about, because we will not have the ERISA waiver.

So, pay-or-play—in other words, in Florida—you can pass a pay-or-play up here. I cannot pass one in Florida because of things like ERISA and other requirements that you have.

Mr. Dingell. Tell me, Governor, you will also see, then, a cut in the level of benefits as well as a retarding of the time at which these——

Governor Chiles. What we will see, Mr. Chairman, is a continued growth in the health care cost. This Medicaid growth over the last 10 years in Florida was 365-percent increase.

It is the driving force that takes all of my money, so I cannot spend money for education or I cannot spend money for law enforcement or I cannot spend money for other programs that I want to in my State, because I am forced, under your Federal mandates, Congressman Rowland, that I helped to pass when I was up here—you know, it siphons all of the money, and we cannot control the cost, because it does not give us the ability to manage care, it does not give us the ability to get away from fee-for-service, those kind of things, and without that and just providing access, we know we will never be able to control our costs.

Mr. Dingell. Does this proposal that you are discussing with us now give you the ability to control costs?

Governor Chiles. Yes, sir.

Mr. DINGELL. How about the cost-benefit ratios from the standpoint of the State and from the standpoint of the Federal Government?

Governor CHILES. It will help both, because if Florida's grew 365 percent, the Federal share is 55 percent of that, and you know what that portion of our national budget that has been and how out-of-control it is.

So, it is growing exponentially, and unless we do something to control that, we will not control costs, and that is why we are saying access is the key, with cost containment, with going to managed care rather than fee-for-service, with making sure we control some of the liability costs.

It is putting all of these things together with having the private sector participate more, with having some kind of a minimum benefit package that gives that basic family the coverage that they need.

Mr. DINGELL. Now, Governor, I think this is probably something you would like to submit for the record, and I think maybe you would like to have your health people give you and us more guidance. But preliminarily, how would you guide us in trying to define the yardstick by which State plans should be evaluated under a national health program if we afford States the latitude to do a reasonable and——

Governor CHILES. I would like to submit that for the record, but I can just tell you briefly, what we would do is we would suggest and only suggest, because the expertise of yourself and Henry Waxman and all of the other people that have worked in this should be used, but what we would say as the criteria would be they should be outcome measures that you ought to hold us responsible for, and the outcome measures could be like, you know, what would your fraud ratio be, what would your coverage be?

Even if you wanted to say what would your infant mortality reduction be, what would your low birth-weight rate be, give us some outcome measures or targets and say we will measure you, but we will give you the ability to determine how you ought to get there, because we have different areas in my State, rural and urban.

I need to treat those in different ways, and if you mandate something that I have to do everything in exactly the same way—so, the more flexibility, the more freedom of passing the money down, but then make us have to enter into an agreement with Washington of what outcomes we will produce, and then police us by how we meet those outcomes, and make us show you what the audit trail would be, because there ought to be a way of auditing that, and I could provide that better for the record in more detail.

Mr. DINGELL. Governor, if the committee were to suggest that we ought to change the law with regard to waivers, to encourage the kind of innovative thing you are trying to do with regard to the health care plan that you have been discussing with us this morning, how would you guide us?

How would you change that waiver law, and how would you change other practices of the Federal Government with regard to Medicaid, to assist you in carrying out those purposes?

Governor CHILES. The first and sort of simplest thing would be where waivers have been granted before, that ought to be a blanket. States should not have to go through the same thing, if they have a similar situation. States should not have to renew waivers that have been successful in the past. That just should be a given.

Mr. **Dingell.** That is part of it, and an important part of it.

Governor **Chiles.** Yes, sir.

Mr. **Dingell.** I concur with that.

Governor **Chiles.** Yes. That is the simplest thing.

Mr. **Dingell.** Yes. That is the easiest one, right?

Governor **Chiles.** Yes. That ought to be easy, but today, it is not there.

Mr. **Dingell.** The Secretary is going to be before us to discuss this.

Governor **Chiles.** I think something like the Leahy Bill and what is the House Bill?

Mr. **Mangano.** McDermott.

Governor **Chiles.** The McDermott bill provides for 5 or 10 States to just be given some blanket waivers in these areas, and then you monitor them and see how they do. I think that would be a major step, that or simpler—something like that tacked on to whatever passes out this year.

We think Florida would be one of those States, because—and we would like to be one of those States. We think that would allow us to experiment with the four areas that we are talking about. Other States might pick a little different area. I am sure Hawaii would jump into that, Oregon would jump into that, Arizona would jump into that and there are some other States that would be out there. I think you would get a lot of data very quickly.

Mr. **Dingell.** Governor, you are of the view that then your State plan, the State Care Program you have been discussing with us, will, in fact, be cost-benefit favorable?

Governor **Chiles.** Absolutely. Now, Mr. Chairman, I cannot say that it would be that on year one; but if you want to take 5 years, I can show you very quickly how it would be cost-beneficial, and probably within less than that it would be cost-beneficial.

Mr. **Dingell.** Governor, would you just want to comment on how the absence of national health care policy affects the States, both in terms of providing health care to their citizens and also——

Governor **Chiles.** Mr. Chairman, it is the greatest problem that my State faces, our people face. I think it is the greatest domestic problem that we, as a country have. It is also sapping all of our reserves and our money for the reason that we are sort of afraid to go into it because it is going to cost money. We are taking money that we could use for reindustrializing this country, for re-educating this country, for retraining, for retooling. All of those dollars are being eaten up and they are producing nothing for us because our population is not even health in compared to the rest of the developed nations because of the way we do it. It is the greatest waste that is out there. It is the most single thing I think now that, in effect, the Cold War is over, that we ought to be addressing.

You have always heard me say before the deficit is the greatest problem, and it is; but, unless you address the health, you cannot address the deficit.

Mr. **Dingell.** Because this is one of the entitlement programs that is causing, in a very major way——

Governor CHILES. Absolutely.

Mr. DINGELL [continuing]. The deficit, which is ongoing.

Governor CHILES. Absolutely. Absolutely.

Mr. DINGELL. Governor, I am going to apologize to you. I have to leave to go to another meeting, but Dr. Rowland is going to preside.

I want to express to you my personal thanks and gratitude for being here.

Governor CHILES. Mr. Chairman, I want to thank you and this committee for your courtesy, but also for what I hear is a tremendously pleasing sound, an encouraging sound that we can move forward in a partnership with this. That is exactly what we need.

We have decided, in Florida, we cannot wait for the Federal Government, but we desperately need you as our partner in this.

Mr. DINGELL. Well, we are going to begin doing some drafting in the areas you have been discussing, and also see what should be done with the regulatory relief.

I want to express my particular thanks to you and to your people down there who have been spectacularly cooperative. If you would keep April 3rd in mind, you and I may be out in the woods with some very good friends doing something very well worthwhile.

Governor CHILES. Thank you, Mr. Chairman. That is a magic date, April 3rd.

Mr. DINGELL. Doctor.

Mr. ROWLAND [presiding]. Governor, I do not know what your time constraints are. There are so many things I want to ask you. There are several areas that I want——

Governor CHILES. Mr. Chairman, I have about 6 minutes—they said 5 or 6 minutes.

Mr. ROWLAND. Left?

Governor CHILES. Yes, sir.

Mr. ROWLAND. Gosh, we cannot do much in that time, can we? Well, let me ask you, or perhaps I should address this to Rae Grad, who is the executive director of the Commission to Prevent Infant Mortality. There is one area that I want to cover very briefly and see how you are trying to address this in Florida.

Governor CHILES. Yes, sir.

Mr. ROWLAND. When you left the U.S. Senate and went to Florida and became Governor there, I had the distinct feeling you had jumped from the frying pan into the fire. I am sure that you will be able to deal with that very well.

I want to ask you a little bit about the problem with teenage pregnancy that we have in our country, and how you may anticipate dealing with that? I have an article here from the Atlanta Constitution, the day before yesterday. One of the cities in the lower part of my State of Georgia has reported that in 1989, 22 percent of the babies born in that area were teenage mothers. Every hospital in the country has seen pregnancy increase among girls who are still too young to drive, vote or join the Army.

I met with a group from a clinic in my home town of Dublin, GA, who operate a prenatal and postpartum clinic there, and they tell me that teenage and adolescents coming back for postpartum care are not interested in birth control—that is not what they want. They intend and say quite frankly, I am going to have another baby as soon as I can. As I mentioned earlier, 40 percent of the OB in Georgia now is under the Medicaid program.

Infant mortality is one of the problems that we have in this particular group of people. Do you have any thoughts about how you are going to deal with this problem in the State of Florida, under the proposals that you are making, or have you looked at that yet?

Governor CHILES. Part of our investment budget, and it kind of fits in with this, is trying to deal with that. I have found—our experience has been, where we have used like resource mothers, and brought these women in that, at the time they were going through their postpartum and the time they were going through their prenatal care, it was the best opportunity that you had to really counsel with a women. I am not sure, in your clinic, whether they are really doing any counseling.

Resources Mothers, as you know, are taking somebody that successfully raised their kids, they are not a nurse, but they are trying to tell these young girls how they can have a life of their own if they stay in school, how they can slow up that next pregnancy, and what the reasons are and why the reasons should be there.

I continue to hear the myth that these women want to have these babies because they get more money. That is not true in my State. Hell, we pay just $20 over the minimum in AFDC, so they are not getting more money. They—and, basically, what we found is where they are given the right kind of counseling, we have seen some amazing successes in the return rate of pregnancy. Normally you could say a 13 year-old having a child is going to have three by the time they are 18.

We have been able to show, in a number of areas, where you can reduce that at least 50 percent and sometimes higher. Now, the other strategy that I think works better than anything I have seen in my State, is school-based health clinics that give family planning information.

We are encouraging that, and that is another phase of our investment budget, is to open a number more. We asked some counties to, you know, provide—see whether they wanted to, and they fought themselves to sort of get in for the few that we provided for. We are providing for more.

It will be up to parents to decide what kind of information that you give them. We have the Quincy Clinic, the school-based health clinic that was at a high school in Quincy FL., reduce teen pregnancy by 75 percent in the first year. That is our standard or what we use. That is a very very successful device.

I think—you know, what you are seeing is sexually active teenagers. Trying to say you are not going to provide information and family planning devices or what not is just kind of crazy.

We are finding, again, in our postpartum services, that many of these women are asking for Norplant. We are trying to get the funds to be able to provide it, which gives us a 5-year leeway—where, again, they requested it, it is something they are seeking.

Mr. ROWLAND. One other question that I want to ask in a different area that I am very much concerned about, is the spread of AIDS, and how that is going to impact adversely, severely on our health care delivery system. It certainly is going to cause a great deal of problems in any plan that is put into place, insofar as funding is concerned. Have you given much thought about the AIDS problem and the increase in opportunistic diseases such as tuberculosis?

Governor CHILES. Well, again, it goes a lot with trying to get the information out there. Certainly, what we are seeking of trying to be able to treat the cases you have in the most economical way, makes sense.

Mr. Chairman, I do not want to say that we have got an answer to it, because we do not. In Florida, we are fourth in population and, I think, third in the number of AIDS cases, so it is a major problem for our State.

Mr. ROWLAND. Thank you very much.

Mr. Bilirakis, do you have any additional comments?

Mr. BILIRAKIS. No thanks.

Mr. ROWLAND. Governor, thank you so very much.

Governor CHILES. Thank you, Mr. Chairman. I do have the opportunity to just speak for a minute about the Infant Mortality Commission Report, which Rae Grad is going to testify in great detail. I cannot think of a better way to illustrate why we have to succeed in our reform plans in Florida, than to talk about this report. Troubling trends persist.

Two years ago to the day, the commission released the first report on troubling trends, in which we tried to sound that loud and clear warning. Today, we see that a lot of people did not hear our warning. Not only is our Nation's progress slow in the number of areas, we are actually going reverse in some. This cannot continue, if we are going to have healthy families, children that are able to learn, a productive workforce for the next century. It is just too costly, in terms of money, human suffering and potential.

I am proud to report to you that we have heard the message in Florida, and we have responded with our Healthy Start Program. In our first year, the major aim was guaranteeing that all women have readily access to adequate prenatal care and their infants receive the health care they need. This is front-end, cost-effective prevention.

We are proud that Healthy Start and our Florida Health Plan is going to give us the ability to go through with that to speed that up. We, again, just say that getting the ability to cut some of the Federal red tape would be tremendously helpful.

I, again, congratulate you on all of your service in the Infant Mortality Commission and certainly Rae Grad and all of the people that we have who work so hard there.

Mr. ROWLAND. Thank you very much for being here today, Governor.

The next panel is Ms. Rae Grad, Executive Director of the National Commission to Prevent Infant Mortality. She is accompanied by Mary Carpenter, who is a registered nurse also, and is Deputy Director.

I thank both of you for being here this morning.

Rae, you and Mary have heard that testimony in this committee is under oath. Do either one of you object to testifying under oath? Do either one of you desire counsel? There is a copy of the rules of the committee and the subcommittee in front of you, if you, at any time, feel you need to refer to those, they are there.

So, I would ask you to both rise, if you will, and raise your right hand.

[Witnesses sworn.]

Mr. **Rowland**. You may now consider yourself under oath. Let me welcome both of you here. I have been so pleased, over the past several years, to have the opportunity to work with you. You have both done a wonderful job in trying to deal with this problem of infant mortality.

So, you may give us your opening statement in any way you choose.

TESTIMONY OF RAE K. GRAD, EXECUTIVE DIRECTOR, NATIONAL COMMISSION TO PREVENT INFANT MORTALITY, ACCOMPANIED BY MARY BRECHT CARPENTER, DEPUTY DIRECTOR

Ms. **Grad**. Yes. Thank you Congressman Rowland and the committee.

I have prepared many hearings and helped witnesses and read many testimonies myself, and what I would like to do is submit my formal testimony for the record, and spend my time with you just talking from my heart.

Mr. **Rowland**. Without objection.

Ms. **Grad**. And from some of my experience.

As you know, I am here with Mary Carpenter, my deputy director, and we will answer any question afterward, if you would choose to ask them.

We are here to release the report which Governor Chiles talked about, "Troubling Trends Persist, Shortchanging America's Next Generation."

The first report we did on Troubling Trends was 2 years ago, it had some very dismal statistics. I was hoping that 2 years after that report we would have a red, white and blue report saying that I could retire and open a restaurant and do something else with my time. It did not work that way. I am troubled that we have to submit a second Troubling Trends report.

What I would like to do, Congressman Rowland, is to be put out of a job. I know that sounds strange, because I really enjoy my work. I do not get it. I do not get why I have to write a second report like this, I do not get why I have to testify in front of you, I do not get why Mary and I have to work 12 and 15 hour days and most weekends. It should not be this hard. This is children we are talking about, this is babies we are talking about, this is the next generation we are talking about.

So, why is it so hard? Why, when I go to parties and people say, Rae, you have the best job in the world, motherhood and apple pie, it must be so easy. I say, I am tearing my hair out on a daily basis. It is not easy. In a sense, I know I am testifying in front of you, but my question goes back, why does this problem have to remain? It is very troubling to me.

We have some statistics over here that show, yes, invent mortality, overall, is coming down, it is now at 9.8 deaths per 1,000 live births, which is the lowest it has ever been. Well, on the one hand, I am ecstatic, this is great news. On the other hand, I cry every night, because the way we got to this point is not that we are preventing low birth weight babies from being born and not because we are doing a better job in prevention; all we are doing is inventing better tubes and whistles and pumps and technology, and we are saving low birth weight babies.

If you look at a concomitant statistic which is in Troubling Trends, which is how many babies are born low birth weight, this is the highest it has been since 1984–1978. The highest it has been. Well, this is crazy. We should not have to have this problem.

This is not a partisan issue. I have worked on this issue my whole professional life, and I do not care if it is republican leadership or democratic leadership. I do not care if Lyndon LaRouche wants to lead on this battle. Fine by me.

Mr. ROWLAND. Do not get carried away.

Ms. GRAD. OK, I change my statement.

My point is, somebody has to buckle down and say it is unacceptable. It should not just be Mary and me and Governor Chiles and you, Congressman Rowland, fighting and fighting and fighting. We need the troops, we need the battlefields filled with people like us saying this is unacceptable.

What I find also very troubling, and this is coming out more and more over the past year or so, is a blaming the victim mentality. We say—we condemn these women, we say they are not eating right and they are doing drugs and they are abandoning their babies and they are doing all this kind of terrible stuff. I would like anybody who makes that statement to walk in the shoes of these women for 24 hours and see what it is like to live in substandard housing, to live without the promise of dinner that night, to live with the threat of violence every time they step outside their door. I would ask anyone to live in that condition and just see how well you do.

We are very privileged. We have roofs over our heads, we have dinner on the table. Unless you walk in someone's shoes, you cannot make judgments about that person, even as far as drug abuse.

I have come a long way in my understanding of crack and different kinds of drug abuse. This is not the chosen option for women who are pregnant, this becomes an escape route, because everything else in their lives is so dismal, and we offer no treatment for these women. So, we cannot blame the victim.

I get letters in my office that say I am my brother's keeper, I want to take care of children. There is usually a parenthesis, as long as these children are white or wealthy or middle class. You cannot make a differentiation. If you are going to save babies, you are going to save all babies. We cannot blame women for situations that they cannot help.

We showed a movie earlier this week called "Shattered Lullabies," which was produced by a company called Vous Productions, in Hollywood. Steven Speilberg and Kate Capshaw were in it. It was quite an amazing film, because I think it broke some of the preconceived notions of what this problem is all about.

I think we want to believe that it is only inner-city, inner-city Detroit, inner-city Washington problem there, and what you see in this film very clearly is that the problem is widespread. These are problems happening to two-couple working families, to white families, to Hispanic families, to working and hard-working people, and it is just not what some people think it is, and that is an inner-city problem only. It is in the rural area, it is in the urban area, it is in the white population, it is in the African American population, it is everywhere. So, it means all of us have to pay attention.

There is another concept that I want to make sure we all understand, and that is the concept of morbidity. We talk so much about mortality, the babies that die. None of these charts reflect morbidity, which, in many cases, is the critical piece of information, because those are the babies that live, but at a risk of handicapping or disabling conditions which affect them their whole lives.

We pay. It is just like Governor Chiles said, it is so true. We pay for this one way or another. If we do not give a woman prenatal care, we pay for her repeated visits to the emergency room, when she is not sure what is going on and this happens. So, I think we have to regroup and understand that the morbidity, the problem, the at-risk problems is, in many ways, as important, if not more important than the mortality.

Then there is the issue of quality of care. When we say, how many women get prenatal care? When we talk about what it means, I think we have to be very careful to make sure we know what it means, and it is not just a blood pressure taking and a urinalysis testing. It is a whole array of services that we could, in essence, provide to the mother, if we choose to do it, but we are not choosing to do it.

I speak of this from very personal experience. You know I am a nurse and I worked in labor and delivery for many years. Currently, I still work as a nurse one night a week in a high-risk clinic in the District and Anacostia. I was there last night. I had to leave early, but I found out my volunteer staff stayed until nearly 10 p.m. last night, after coming to work at 7:30 in the morning, all volunteers. Because we have to do something about what is going on in the District.

Well, the women that I had last night were just the same as the women I have had for the same 2½ years; good women, strong women, honest women, women who are trying hard. They just cannot make the system work. They need so many services. They need GED counseling, they need sexually transmitted disease counseling, they need immunization assistance for their other children. We cannot offer that because the system ties us up in knots.

It is just what Governor Chiles said, it is not that we do not have the intent, but I would have to spend my volunteer time getting waivers even just from the District to be able to give the services that I want in this clinic. It is unconscionable.

So, the Troubling Trends report gives us a very sobering notion of just what is going on today. The infant mortality rate, as I said overall is down, but we still rank 22nd worst among industrialized nations. There is no reason for this when we spend more per capita on health care than any other nation in the world.

As you know, the infant mortality rate for African American babies is twice that of the white population. That is true in every instance except one, and I want you to think about this—that it is true, except in the military. You say to yourself, well, why are African babies born in the military doing just fine, same rate as the white population? Well, maybe it has something to do with universal access to care and guaranteed housing and guaranteed food and guaranteed education. I mean, these things—it is not a biological imperative that some babies die and some do not.

So, we would like to make it to seven deaths per thousand live births in the year 2000, which is the year 2000 goal set by the Department of Health and Human Services. We will not make it. There is no way. We are not going to make it. I will be surprised if we get much lower than what we are today.

Low birth-weight—we are at 7 percent of all our babies being born low birth-weight. That is the highest since 1978. Well, what does that say? That says more babies are born at risk, and all we are doing is saving them with expensive technology.

We would like to get the low birth-weight rate to 5 percent in the year 2000. We are not going to make it.

We have to look at the risk situations affecting families: poverty—we know the increase in poverty—drugs, sexually-transmitted diseases. Everybody in my clinic has a sexually-transmitted disease for all intents and purposes. It is unbelievable, and Congressman Rowland, we do not even check routinely for AIDS.

I am sure that we are having people walking around HIV-positive, but we do not have the capacity to test everybody for AIDS, and this is such a high-risk population, and they are all spreading the disease, and there is no checkup, and there is no family planning in the schools. It is a real problem there.

So, the risk situations of poverty, drugs, and sexually-transmitted diseases are on the rise. Teen pregnancy remains. I am like you. I do not know why these girls keep having babies, but maybe it something to do with the fact that we are not giving them family planning.

I mean, like Governor Chiles said, there is a critical moment, and if we keep taking it out of the schools and taking it out of these children's lives, what do we expect?

One of the Medicaid rules that is in place now is that, if you are on Medicaid postpartum, your coverage for family planning only lasts 60 days.

What is the message you are giving to teens? You are saying, well, go ahead and get pregnant, because we are not going to cover you for family planning services but for 60 days. Well, that does not make any sense to me.

Prenatal care—certainly we have more and more women not getting comprehensive prenatal care, and remember, my definition of prenatal care is quite comprehensive. It means that we need to give the services that are out there.

We are seeing an increase in children with communicable diseases that should have eradicated. I do not know why they are. We need to do a better job.

Why is the situation here? Inadequate funding can always be blamed, but it is more than that. We have lack of coordination between programs.

The bureaucracy is extremely slow to respond, and things that are so simple, like home visiting—why can't we have a national home visiting program? Every other nation in the world that has good outcomes has home visiting. What is so hard about home visiting that we cannot do it in this country?

Now, the Commission has a privately-funded program to do home visiting. So, we are going to try to do it nationally, but why should my office, with my overworked staff, do this? It should be a Federal program.

We should have every community in this Nation with home visiting services. It is low cost and it works. What is the deal? We should do it.

Our report is not a doom-and-gloom report. Governor Chiles and Congressman Rowland, we all believe that we should not just wring our hands. We should do something about it, and what we are proposing is very simple, very straightforward.

First and foremost, universal access to care. We sound like broken records on this team. We must have universal access to care and then ask questions later, and that care must be comprehensive, or else we are going to be paying in the long run.

We must make sure that all mothers and all children have a primary health care provider or we are always going to be filling in the holes. These mothers have questions, these children have problems. We need to take care of it on the front end.

We need to provide family planning information as if it is a normal course of life, which it is, not to make it a hurdle but to make it a natural course of health care so that women can space their pregnancies.

We need to provide services to addicted mothers and children of addicted mothers. Right now, only about 14 percent of all those women who are addicted can get into treatment services. That is ridiculous.

How can we blame mothers for being crack addicts if we are not giving them any treatment programs to help them off crack?

Finally, if we really are serious about this issue, we must make mothers and children a priority, a real priority, not an election-year priority but a no-kidding, I'm-not-going-to-go-away priority, and that is why Mary and I work hard. That is why Governor Chiles and Congressman Rowland, as vice chair and chair of our commission, keep this issue in the forefront.

I really would like not to have to testify in front of this committee again, not because you are not wonderful people, because I want this issue to go away.

I thank you very much.

[Testimony resumes on p. 414.]

[The prepared statement and attachments of Ms. Grad follow:]

TESTIMONY OF
RAE K. GRAD, PhD, RN

Mr. Chairman, Dr. Rowland, and members of the Subcommittee, thank you for inviting me to be here this morning. I am Rae Grad, Executive Director of the National Commission to Prevent Infant Mortality. I am pleased to join the Commission's Chairman, Governor Chiles, to release our report, Troubling Trends Persist: Shortchanging America's Next Generation.

As Governor Chiles described, Mr. Chairman, our nation's mothers and children are in trouble. The warning signs have been right in front of us for some time now, but we as a nation have chosen to ignore them. In addition, the solutions to the problems confronting them also have been right in front of us, but we have chosen to ignore these too. As a result, we find that the United States is falling even further behind other developed nations in infant mortality, low birthweight babies, childhood mortality, and childhood immunizations. When we cite the statistics and note our poor international standing, it sounds like so many numbers. But in fact, behind each and every number is tragedy and pain beyond our comprehension as we sit in this comfortable committee room -- tragedy felt not only by the poor and disenfranchised of our nation, but by families from every walk of life, and costs that reach into the billions in terms of health care dollars and lost potential for these children.

The Commission released a report about two years ago similar to this one today. In it we cited numerous statistics, research findings, and other factors affecting maternal, infant, and child health. The Commission also made several recommendations about how we could turn these trends around. The Commission staff tracks legislation, model programs in communities and regions throughout the country, media coverage, and other initiatives to improve maternal and child health and, I'm pleased to say, there are many people across the country who are dedicated and committed to these issues. Yet, as the name of our report, Troubling Trends Persist, indicates, it is not enough.

In our report, we also compare our current progress in infant mortality, low birthweight, receipt of early prenatal care, drug and alcohol-addiction during pregnancy, childhood immunizations, and other areas, with the Year 2000 Health Objectives for the Nation established by the U.S. Public Health Service. In a nutshell, Mr. Chairman, we will have to greatly step up our current level of effort in all these areas if we even want to dream of reaching these goals. In fact, in several of them, we are actually going in the wrong direction.

Let me briefly outline our findings:

- In 1989, the most recent year for which final data are available, the national infant mortality rate was 9.8 deaths for every 1,000 live births. This was a slight reduction from the previous year's rate of 10.0, but other countries are improving much faster than we are and we are falling further and further behind. We now rank 22nd in the number of babies who die in their first year of life. Japan's rate is less than half what ours is. Most minority groups in America fare more poorly than whites, especially African American babies. They continue to die at more than twice the rate of whites. Other groups whose rates are worse than the white rate include Puerto Ricans, American Indians, Alaska Natives, and Hawaiians. In addition, and this may be a surprise to some, babies in rural America are just about as likely to die as babies in urban areas. Across the country, the states' rates of infant mortality vary considerably, with the best being Vermont with a rate of 6.9, and the worst, South Carolina, at 12.8.

  The Year 2000 goal for infant mortality is 7 for all racial and ethnic groups combined. With the slow progress we are making, it is doubtful we will reach this goal.

o The percentage of infants born low birthweight in 1989, 7 percent of all births, was the highest level since 1978. These infants are more than 40 times more likely to die within the first month of life. Clearly, low birthweight is a leading cause of infant mortality and, with adequate prenatal care, most of it can be prevented. The United States ranks behind 30 other countries in this measure. Obviously, they're doing something we are not, and that something is called prevention.

The initial hospital costs alone for a low birthweight baby averages seven times the cost for a normal weight infant. Low birthweight babies also are 2 to 3 times more likely to suffer long term disabilities, including learning impairments, respiratory difficulties, and hearing and vision problems, just to name a few. Low birthweight infants often become children who are more likely to suffer school failure and need special education than children who were normal weight babies. This bodes poorly for the national education goal that all children will be ready to learn by the time they reach school age. Indeed, to reach this goal, we must begin to help children in the prenatal period when the first opportunity to ensure healthy development is most apparent.

The Year 2000 health goal for low birthweight is 5 percent for all groups combined. Not only are we not likely to reach this goal, current trends are going in the wrong direction.

o One of the most powerful predictors of infant mortality is poverty. Poor families have more trouble obtaining the basic health care they need like prenatal care and preventive pediatric care, having a nutritious diet, and having a warm, safe, and nurturing home in which to live. The number of families living in poverty is on the rise, and the percentage of young children in poverty, currently about one in five, is much higher than in other developed countries. If the current trends continue, by the year 2000, one in four children, or 25 percent, will be in poverty.

Other risks to good maternal, infant, and child health are increasing. According to one recent estimate, nearly 20 percent, or over 739,000 pregnant women each year use one or more illegal substances at some point during their pregnancies. This is a dramatic increase over the mid-1980s and cuts across racial and socioeconomic lines. While the jury is still out on just what kind of long term damage these babies may suffer, the additional medical expenses for infants who have been exposed to cocaine prenatally total an estimated $504 million per year. Prevention here is the key but, tragically, drug treatment for pregnant women and women with children is virtually unavailable. The U.S. General Accounting Office reported that in 1990, less than 14 percent of the 4 million women in need were able to get treatment.

- Highly associated with the increased use of drugs during pregnancy is the growing incidence of AIDS and other sexually transmitted diseases among pregnant women, women and men overall, and infants. Forty percent of newborns who contract syphilis from their mothers die. Thirty percent of infants born to mothers with AIDS or who are infected with HIV, will actually develop AIDS. And they all will die within a few years.

- While adolescent pregnancy and parenthood are not new phenomena, their magnitude and circumstances have changed over the years. The rate of teen pregnancy rose in the late 1980s and, by 1989, nearly 13 percent of all births were to 15 to 19 year olds. Pregnant teens are high risk due to their higher rate of poverty and their likelihood of not receiving adequate prenatal care than older mothers.

- For all women and especially for high risk mothers, comprehensive prenatal care, starting early in pregnancy, is the best method available for preventing infant mortality and for preventing many of the behavioral, social, and other factors that place a woman at risk for having an unhealthy baby. The value of prenatal care has been known for decades, yet, fewer and fewer women are receiving early care. In 1989, less than 76 percent of women received early prenatal care and, for most minority groups, the percentage is even lower. Even though Congress and the states have expanded Medicaid coverage for pregnant women and children over the past several years, this is not the only approach that is needed. Millions of women and children remain uninsured and cannot afford care, plus countless nonfinancial barriers to care continue to stymie even the most diligent and persistent women.

- Perhaps one of the most glaring examples of the fact that we do not have our house in order is that the United States is experiencing an epidemic in preventable childhood diseases, especially measles, mumps, rubella (German measles), and pertussis (whooping cough). In 1990, more than 25,000 cases of measles were reported, resulting in over 60 deaths. This is deplorable for a nation that invented many of these vaccines in the first place!

  This crisis illustrates our failure to reach children through our health care and other service systems. Not surprisingly, half the children living in low income inner city neighborhoods do not receive their vaccinations by the age of two. To a great extent this is because too many children do not have a "medical home", an identified doctor or nurse practitioner from whom they receive ongoing primary health care.

  The Year 2000 health objective calls for 90 percent of children below age 2 to be fully immunized, as compared to the 1989 baseline of 70-80 percent. If we are to reach this goal, we must act quickly.

While government alone cannot solve our maternal and child health problems, in researching this report, it once again became very clear that our public health and related programs are not keeping up with the needs of our most at-risk mothers and children, despite their efforts. Part of it is inadequate funding levels. Programs that have been proven effective, such as the the Maternal and Child Health Block Grant program, Community and Migrant Health Centers, the Special Supplemental Food Program for Women, Infants, and Children (WIC), and the federal childhood immunization program need further support. Part of it is the lack of coordination between the myriad programs. Efforts to create one-stop shopping for services must be made. And, part of it is that the bureaucracy is extremely slow to respond, if it responds at all, to strategies that have been proven effective. One example is home visiting services. A home visitor, who is a trained lay person right from the community, can provide that vital link between at-risk women and children with the health, housing, social, and other services they need. Home visiting is readily available in most other countries, but not here. The Commission has a project to develop training materials and help communities across the country implement home visiting programs. Why is this not being done by the federal government?

Mr. Chairman, the findings in our report are very troubling, and our lack of progress to improve them is even more disturbing and frustrating. But Governor Chiles and I are not here to just wring our hands or place blame. Ours is not a doom and gloom report. This nation has the capacity, resources, and knowledge to turn these trends around immediately. The United States is an anomaly among industrialized nations. We spend more on health care and have more technology at our fingertips than anyone else. Yet we don't do all we can to provide all of our citizens a healthy start in life. That, Mr. Chairman, is a problem of priorities, it is not a health or technology problem.

Our recommendations in this report build on the recommendations made back in 1988 when the Commission presented its first report to Congress and the President as was mandated in the Commission's original legislation. For example:

- To assure that all people have the best possible start in life, we must begin by assuring that all women receive prenatal care; that is, care that is comprehensive, that addresses health and behavioral risks, and that starts early in pregnancy. This can be accomplished through increasing financial access to care, breaking down the nonfinancial barriers to care, and alerting women to the importance of prenatal care and how and where to get it. There is no mystery here, only a lack of commitment and action.
- All children need a primary health care provider from whom they receive preventive care, including immunizations, and from whom their parents can get guidance about their children's growth and development. Again, no mystery, only a lack of action.
- All women need family planning information and adolescents especially need family life education and they need to know what their life options really are. It is shortsighted to assume that the problem of teen pregnancy will just go away. It is not going away; it is increasing.
- Women who are addicted to substances during pregnancy need treatment and prenatal care, period. It is the only way to turn around a terrible situation, to assure a healthy baby, and to prevent repeat abuse.
- To make any -- and preferably all -- of these recommendations a reality, this nation must make the health and well-being of mothers and children a top priority.

All sectors of society have a role to play in turning these troubling statistics around. One sector cannot possibly do it all. At the Commission, we work with business groups, community-based organizations, health and education professionals, the media, and others to encourage them to get involved. We know that Americans will rally to improve the health of mothers and children, but they need leadership that policymakers, business leaders, religious leaders, and other notable individuals and groups can offer.

Mr. Chairman, our report includes more detailed statistics and recommendations, so I will not go into them here. I would like to close with a few final thoughts. Even though we are reporting that the nation is unlikely to reach the year 2000 health goals for infant mortality and other indicators of maternal and child health, this prediction can be turned around. The United States must make a commitment to our mothers and children and make their health and well-being a top national priority. We must reorient ourselves from crisis intervention to prevention. It saves lives and money. We must do this and meet the challenges, so we do not end up shortchanging our next generation.

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Infant Mortality Rates
Ranking of the Developed Countries, 1989(a)

Rank	Country	Infant Mortality Rate(b)
1	Japan	4.59
2	Sweden	5.77
3	Finland	6.03
4	Singapore	6.61
5	Netherlands	6.78
6	Canada	7.20(c)
7	Switzerland	7.34
8	France	7.36
9	Hong Kong	7.43
10	Federal Republic of Germany	7.44
11	Ireland	7.55
12	German Democratic Republic	7.56
13	Norway	7.72
14	Australia	7.99
15	Spain	8.07(c)
16	Austria	8.31
17	United Kingdom	8.42
18	Denmark	8.45
19	Belgium	8.64
20	Italy	8.80
21	Greece	9.77
22	United States	9.80
23	Israel	9.94
24	New Zealand	10.19

Source: National Center for Health Statistics

(a) Singapore and Hong Kong, not defined as "developed" by the U.N., are included in the ranking since they have infant mortality rates below the U.S.

(b) Number of infant deaths per 1000 live births

(c) Rate is for 1988

INFANT MORTALITY AND LOW BIRTHWEIGHT
BY STATE, 1989

Rank	State	Infant Mortality	Low Birthweight		
		All	All	White	African American
1	Vermont	6.9	5.5	5.4	*
2	Minnesota	7.1	4.9	4.5	13.3
3	Maine	7.4	4.9	4.9	*
4	Massachusetts	7.7	5.9	5.3	11.0
5	Nebraska	7.9	5.8	5.2	14.0
6	New Hampshire	8.0	5.1	5.1	*
6	North Dakota	8.0	5.0	4.9	*
6	Utah	8.0	5.7	5.6	14.5
9	Nevada	8.1	7.2	6.3	15.7
10	Hawaii	8.3	7.1	5.6	10.9
10	Iowa	8.3	5.4	5.3	11.0
12	California	8.5	6.1	5.3	13.7
12	Oklahoma	8.5	6.5	5.9	11.7
12	New Mexico	8.5	7.0	6.9	11.5
15	Colorado	8.7	7.8	7.4	14.2
16	Connecticut	8.8	6.9	5.7	14.6
16	Kansas	8.8	6.1	5.5	12.9
18	Oregon	8.9	5.2	5.0	12.5
19	Wisconsin	9.1	5.8	4.8	14.1
20	Alaska	9.2	4.9	4.5	8.7
20	Arizona	9.2	6.3	6.1	14.0
20	Kentucky	9.2	6.9	6.3	11.9
20	Texas	9.2	7.0	6.0	13.1
20	Washington	9.2	5.6	5.3	12.5
25	New Jersey	9.3	7.3	5.6	13.9
26	West Virginia	9.4	6.6	6.4	13.8
26	Wyoming	9.4	7.3	7.2	*
28	South Dakota	9.6	5.4	5.1	*
29	Idaho	9.7	5.5	5.5	*
30	Florida	9.8	7.7	6.0	13.0
31	Missouri	9.9	6.9	5.7	13.1
31	Ohio	9.9	7.0	5.9	13.6

Rank	State	Infant Mortality	Low Birthweight		
		All	All	White	African American
33	Virginia	10.0	7.1	5.4	12.3
34	Arkansas	10.2	8.3	6.6	13.8
34	Indiana	10.2	6.6	5.9	12.7
34	Pennsylvania	10.2	7.1	5.7	14.9
34	Rhode Island	10.2	6.2	5.6	12.0
38	Maryland	10.3	8.0	5.8	13.1
39	New York	10.6	7.7	6.0	13.7
40	Tennessee	10.8	8.2	6.5	13.7
41	Michigan	11.1	7.6	5.6	15.4
42	Montana	11.3	5.5	5.4	*
42	North Carolina	11.3	8.1	6.0	13.0
44	Louisiana	11.4	9.1	6.1	13.4
45	Mississippi	11.6	9.4	6.5	12.6
46	Illinois	11.7	7.7	5.6	14.5
47	Delaware	11.8	7.5	5.7	13.1
48	Alabama	12.1	8.3	6.2	12.3
49	Georgia	12.3	8.4	5.8	12.9
50	South Carolina	12.8	9.2	6.5	13.4
	United States	9.8	7.0	5.7	13.5

Source: National Center for Health Statistics, "Advance Report of Final Mortality Data, 1989", Monthly Vital Statistics Report, Vol. 40, No. 8 (S), December 12, 1991

* In these states, too few African American infants were born low birthweight to calculate a rate.

NATIONAL HEALTH OBJECTIVES FOR THE YEAR 2000 COMPARED TO 1989 UNITED STATES HEALTH INDICATORS

Subject	Goal	Current Rate	Likelihood of Reaching Goal by Year 2000
Infant mortality			
All races	7/1,000	9.8/1,000	Increased efforts needed
African American	8.5/1,000	17.7/1,000	Increased efforts needed
Low birthweight			
All races	5%	7.0%	Unlikely
African Americans	9%	13.2%	Unlikely
Early prenatal care			
All races	90%	75.5%	Unlikely
African Americans	90%	59.9%	Unlikely
Fetal Alcohol Syndrome	0.12/1,000 live births	0.22/1,000 live births	Increased efforts needed
Abstinence from alcohol and cocaine during pregnancy	Improve by 20%	N/A	Unlikely
Abstinence from tobacco during pregnancy	90%	75%	Increased efforts needed
Immunizations	90% by age 2	70%-80%	Increased efforts needed

Source: U.S. Department of Health and Human Services, Public Health Service, Healthy People 2000, National Health Promotion and Disease Prevention Objectives, 1990

Mr. ROWLAND. Thank you for your testimony, Rae. I really appreciate that. Let me make a comment about one thing that I think has been helpful and, I hope, will be more helpful, and that is the consortium between the Infant Mortality Commission and education.

As you know, we have put together a group, with your valuable assistance, in my own State and have gotten people interested in the middle Georgia area.

We have been able to get people in business, education, and health care all to come together to try to focus more attention on the infant mortality problem that we have. We want to try to do that with better education and better understanding about how to deal with it, and that has seemed to be moving forward very well now. So, I am very pleased with that.

I want to ask you a couple of questions. You mentioned not testing for HIV in prenatal clinics. Could you expound on that a little bit and tell me what you think needs to be done in that respect?

I know that we have talked about testing babies after birth, but some of the problems attendant with testing for HIV present us with a difficult situation. Would you comment on that?

Ms. GRAD. I am not a civil rights lawyer, and I know that there must be some reason why we do not do it, but it is not mandatory. I do not know of any State where it is mandatory for pregnant women. There might be and I am just not aware of that.

Let me just give you the visual scene, and that is I would say at least 80 to 90 percent of the women in our clinic—and this is a normal clinic; this is not abnormal; it is mostly the same all over the country—test positive for one form of sexually-transmitted disease or another.

It could be gonorrhea, it could be syphilis, it could be chlamydia, it could be herpes, and what we know is these diseases tend to cluster. This means that you are already dealing with a high-risk population.

So, my gut feeling is that many of these women are also HIV-positive, but because it is not mandatory and because you have to go through an incredibly complex permission form—I mean the permission form is like four pages long, and it is very difficult to read, and you have to do very lengthy counseling, which we are willing to do, but we do not have the staff to do it—it is not done.

So, what I am afraid of is that it is being transmitted not only to the babies but to other partners, and it is an epidemic, and it is going to remain an epidemic until we figure out some way to test, treat, and prevent, which I think is possible, but we are not even addressing it right now.

Mr. ROWLAND. How would you address it? That is the question. How would you address the HIV testing in prenatal clinics? Are you saying it should be mandatory?

Ms. GRAD. Well, I cannot speak from a civil rights person.

I speak from a nurse person, and as a nurse person, I would like it to be mandatory, just because I would like to know so that we can stop the spread and we can do something about it, but I would take it back a step further, talking about HIV education in the schools.

Should we distribute condoms in the schools? I do not know. That is probably out on the limb to some people, but the truth is, if we do not protect these children, this disease will spread.

So, I would start with education and prevention in the schools. I would like to explore the idea of mandatory testing, but if you do not follow up after the testing, then the testing is no good. It has to be testing, treatment, and followup.

Mr. ROWLAND. You said that there should be universal access to health care. Would you expound on that a little bit? Do you mean through Federal universal access or through the States, like Governor Chiles is talking about now? What are your thoughts on that?

Ms. GRAD. Well, I think there needs to be Federal oversight and Federal guidance, but I really do feel that the States need some flexibility, because the population groups are so incredibly diverse.

I think we have a lot of knowledge from other countries that have done this. We have experience ourselves in doing it for the elderly. In essence, we do have universal access for the elderly. So we figured this out 30 years ago. There is no reason why we cannot figure this out right now.

In truth, I do not think anything is ever going to be a totally Federal program. I think that is unrealistic, but I think looking at public-private match, looking at State flexibility, and looking at prevention as a cost-saving measure, with some Federal oversights and guidance, could certainly be a big start.

Mr. ROWLAND. I had the opportunity, as I mentioned earlier, to visit several western European countries.

Germany was one of those, and the States there were principally responsible for devising their own system, with Federal oversight. That seemed to be working very well, although they are still having difficulty with financing the system.

These are some specific questions that I want to ask you. How much do we spend keeping low birth-weight babies alive?

Ms. GRAD. Something like $2 billion each year, and that is just to keep them alive. If you talk about the long-term costs, I really cannot calculate them. It is just too much.

It is also, on a daily cost—I think—what is it, $2,000-some per day in a neonatal intensive care unit, and that compares to just maybe a couple of hundred dollars if the baby can get discharged. The costs are phenomenal, and I do not think we can totally calculate them, because they go out into the life of the child.

Mr. ROWLAND. How does prenatal care affect the numbers of low birth-weight babies?

Ms. GRAD. Well, I think very directly. We know from many studies, both in this country and in other countries, that when moms get prenatal care, the babies are born better.

Now, there is no guarantee. You will never get to zero, but you will improve the rates, and prenatal care, if you define it the way I do, as comprehensive, total services, can make a tremendous difference.

Mr. ROWLAND. How many of all births are low birth-weight?

Ms. GRAD. Seven percent of all births are low birth-weight, and as I said, that is the highest rate since 1978.

Mr. ROWLAND. What long-term health effects do low birth-weight babies face?

Ms. GRAD. Well, it can be handicapping and disabling conditions like cerebral palsy, things that you can see with your eyes, but what worries me is the longer-term deficits that we cannot put our finger on, things like learning disabilities, attention deficit disorders.

A lot of the problems that we see in schools I feel are attributable to poor prenatal care and poor pediatric care. It is just harder to prove.

Mr. ROWLAND. Does it affect their learning ability?

Ms. GRAD. Absolutely, and I think all you have to do is talk to a first-grade teacher and ask them what they see in the classroom, and it is a pretty cause-and-effect relationship.

Mr. ROWLAND. Do you have any idea how much money is spent on those mothers who are drug abusers?

Ms. GRAD. $504 million is what we think, but again these are very hard numbers to get hold of, because there are many abusers who do not come into the system until there is a crisis, and it is hard to know where to attribute those costs. We say $504 million. My gut sense says that it is probably even higher.

Mr. ROWLAND. What about smoking? What kind of effect does that have?

Ms. GRAD. I do not understand why——

Mr. ROWLAND. The only reason I asked that question is because it was given to me.

Ms. GRAD. I do not understand why we still have pregnant women smoking. It would not be my choice, but smoking is an addiction.

So, it means, to me, that we have to have programs to help women solve that addiction, and there are smoking-cessation programs. The only problem is they are not available in prenatal care.

If we could stop women from smoking, we would lower the low birth-weight rate by 25 percent, but it is hard to give up smoking if you are a smoker.

I am not a smoker, but it is an addiction, and my answer to that is let us put smoking cessation in the prenatal clinics, which it is not now there.

Mr. ROWLAND. The WIC helps save money. Can you give me an idea about how much it saves?

Ms. GRAD. I'm going to let Mary answer that. She knows WIC better than I do.

Ms. CARPENTER. There have been a lot of studies that have shown WIC to be cost effective when you look at women in the prenatal period that get WIC services. There was a study about 2 years ago by USDA that showed that, in five States, women who got WIC during the prenatal period saved Medicaid costs in the range of about $1.77 to about $3.13 in the States, that every dollar that was spent on WIC would save about $1.70 or about $3.13. So just for Medicaid alone, having those women on WIC really makes a big difference in Medicaid savings because of the chance of their having a better baby, better birth outcome.

Mr. ROWLAND. Governor Chiles talked about separating Medicaid from these other programs, separating it from AFDC, WIC, food stamps. Do you have any thoughts about how that would contribute to improving the health care delivery system?

Ms. **Grad**. We already do that. We do separate out AFDC from Medicaid. But what Governor Chiles would say is that there are different kinds of access. That talks about the financial access. If you talk about WIC, that's a different kind of access. Even though it's based on financial eligibility, it's also dependent on nutritional risk. But then you go into this whole other array of services. Some are entitlement and some aren't. What Governor Chiles and we are saying is that notion of one-stop shopping, the notion of putting the services together through eligibility and through service delivery, is really a phenomenal way to go.

There's no reason why WIC has to be offered on a Wednesday and prenatal care on a Thursday and immunizations on a Friday, and all this stuff. This—and each of these programs has a different eligibility form and a different way to get into the system.

We could separate them out from welfare programs financially, but at some point, they have to come together on the service delivery and entry level form.

Mr. **Rowland**. There are some additional questions we will submit to you.

Ms. **Grad**. Fine.

Mr. **Rowland**. And we would be pleased if you would answer those. I want to thank you and Mary both very much for being here this morning and for the report.

Ms. **Grad**. Thank you.

Mr. **Rowland**. The next panel is Mr. Michael F. Mangano, who is Deputy Inspector General for Evaluation and Inspections with the Department of HHS.

Thank you very much for being here this morning. As you already know, testimony in this committee is taken under oath. Do you have any objections to testifying under oath?

Mr. **Mangano**. No, I don't.

Mr. **Rowland**. Do you desire to be represented by counsel?

Mr. **Mangano**. No.

Mr. **Rowland**. A copy of the rules of the committee, subcommittee and the House are in front of you if you need those.

[Witness sworn.]

Mr. **Rowland**. You may consider yourself under oath now. Thank you very much for being here. You may proceed as you so desire, Mr. Mangano.

TESTIMONY OF MICHAEL MANGANO, DEPUTY INSPECTOR GENERAL, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. **Mangano**. Thank you very much, Mr. Chairman. I'm really happy to be here today to talk about the work that we've been doing in the area of quality care for Medicaid beneficiaries.

Because of the concerns of the committee, you have asked us to take a look at three specific issues. The three issues are the use of emergency rooms for non-emergency purposes by Medicaid beneficiaries, the hassle factor for physicians participating in Medicaid, and third, quality assurance in Medicaid HMO's.

What I'd like to do is just summarize the results of those three studies.

Mr. ROWLAND. Your full statement will be made a part of the record.

Mr. MANGANO. The first report, Use of Emergency Rooms by Medicaid Recipients, deals with that issue specifically. We have found that since our work that was done previously in 1983, that there still remains a severe problem in the Medicaid program. We estimate that between one-half to two-thirds of the Medicaid room visits by Medicaid beneficiaries are for non-emergency purposes.

We believe that if those services were delivered in a more appropriate setting in the community through either clinics or physician offices, that a higher quality of care would be given because the community settings would provide more continuity of care, which is preferable.

In addition to that, there would be substantial savings to the Medicaid program. We must understand that emergency room costs to treat a beneficiary are about three times as expensive as similar care that would be provided in a physician's office or in a local clinic.

Medicaid beneficiaries use emergency rooms simply because they don't have access to an ongoing relationship with a physician or a clinic. They either don't live close to a care giver or have difficulty reaching that care giver after hours. Health care providers can also contribute to that problem by referring their patients to emergency rooms after hours.

By the States' own self-evaluation, the process that they found to deal most effectively with this particular problem has been through the use of managed and pre-paid care programs. These programs provide 24-hour access to the beneficiary with a health care provider. That provider is to determine what the health care needs of that beneficiary are and to recommend an appropriate setting for the beneficiary.

The success of these managed care programs in this particular area we believe is hard to document right now, but we do have some indications that they are working.

One area of evidence is that the States of Wisconsin and Pennsylvania in using managed care have been able to demonstrate a drop in the use of emergency rooms by their Medicaid beneficiaries as opposed to those that are in fee for service systems.

We also found that some cost savings can accrue from that. In the years from 1987 to 1989, three of the States were able to demonstrate a $13.6 million savings due to patients being put into managed care programs and avoiding unnecessary emergency room visits.

Let me turn to the second report, which you specifically asked us to take on the last time that we testified before you, Congressman Rowland. That one dealt with the Medicaid hassle factor for physicians.

This seems to be a problem that physicians point to as a reason why they are discouraged from participating in the Medicaid program. The study that we have produced for you today entitled "Medicaid Hassle: State Responses to Physician Complaints" identifies nine specific approaches that we found States using that help reduce that Medicaid hassle. They deal with claims processing, communication between the Medicaid program and the physicians, and finally, confusing provider manuals. Let me just touch on those very quickly.

With regard to claims processing, we found that the difficulty of submitting claims for reimbursement and dealing with problem reimbursements has been addressed in a number of ways by some States.

For example, 28 States now have instituted electronic claims processing which process the claims faster and with less mistakes, and with the opportunity to save the physician money in terms of costs for clerical services in the office.

Several States have instituted automated telephone inquiry systems in which physicians can use a touch tone phone to dial up information about Medicaid eligibility and what the status of their claims.

Finally, some States have issued troubleshooting guides to the physicians which help them identify ways to rectify problems with billing submissions in a very short order.

With regard to communications, we found that some States have instituted partnerships between physicians and the Medicaid program in which they work on common problems together. States like Washington, Alabama and Missouri have put together actual task forces which have helped identify specific areas that they can improve in the Medicaid program.

Manuals continue to be a problem for primary care physicians and reasons why they shy away sometimes from participating in the Medicaid program. Complicated manuals that are not confusing and not written in language that is understandable by the billing staff, et cetera, present problems.

We are happy to note, though, that we found two examples of manuals that really did have a very strong endorsement by the physician community, and the physician community participated in the development of those manuals. The States of Michigan and Maryland are leaders in that forefront.

Because of the problems that I have pointed out so far, States have turned to managed care as really their best alternative to ensure that we have access and continuity of care.

Quality assurance, though, is very important in States using managed care systems because with the capitated payment process that's available under managed care, there is an incentive to under-treat; therefore, States need to have quality assurance mechanisms to assure that that doesn't occur.

In our study, we identified 13 standards that States are using to assure that quality, and they fit basically into three areas: structure, process and outcome. The kinds of standards they're using for structural standards include those things that take a look at the health care resources of the HMO, including the facility, staff, and rules of procedure.

All Medicaid agencies require the HMO's to have patient education programs and provide access to care, and most of them require a written quality assurance program.

With regard to process standards, States have developed key standards that deal with issues of credentialing, utilization review, medical record review, and clinical practices.

The third area is outcomes review. A few of the Medicaid agencies have required the HMO's to come up with the individual outcome procedures themselves, and many of the State Medicaid agencies require the HMO's to have complaint and grievance procedures in place, as well as require patient satisfaction surveys.

That completes the summary of the three reports, and I'd be most happy to answer any of your questions.

[Testimony resumes on p. 447.]

[The prepared statement of Mr. Mangano and summaries of the reports referred to follow. The full text of the reports have been retained in subcommittee files.]

TESTIMONY OF MICHAEL MANGANO, DEPUTY INSPECTOR GENERAL
DEPARTMENT OF HEALTH AND HUMAN SERVICES

GOOD DAY. I AM MICHAEL MANGANO, DEPUTY INSPECTOR GENERAL FOR THE OFFICE OF EVALUATION AND INSPECTIONS, IN THE OFFICE OF INSPECTOR GENERAL, FOR THE DEPARTMENT OF HEALTH AND HUMAN SERVICES. WE APPRECIATE THE OPPORTUNITY TO TESTIFY ABOUT OUR WORK CONCERNING ACCESS TO QUALITY HEALTH CARE SERVICES FOR MEDICAID RECIPIENTS.

BACKGROUND

THE MEDICAID PROGRAM WAS ESTABLISHED IN 1965 AS A FEDERAL-STATE PROGRAM TO PROVIDE MEDICAL ASSISTANCE TO CERTAIN INDIVIDUALS AND FAMILIES UNDER TITLE XIX OF THE SOCIAL SECURITY ACT. WHILE THE PROGRAM IS APPROXIMATELY 57 PERCENT FUNDED BY THE FEDERAL GOVERNMENT, IT IS ADMINISTERED BY THE STATES. THE MEDICAID PROGRAM SERVES OVER 29 MILLION INDIVIDUALS AT AN ESTIMATED TOTAL COST OF $127.2 BILLION IN FISCAL YEAR (FY) 1992, $72.5 BILLION OF WHICH COMES FROM THE FEDERAL GOVERNMENT. TOTAL MEDICAID SPENDING FOR FISCAL YEAR 1993 IS PROJECTED TO BE $148.2 BILLION--A 16.5 PERCENT INCREASE OVER FY 1992 OUTLAYS.

A KEY CONCERN FOR THE DEPARTMENT, WITH RESPECT TO THE MEDICAID PROGRAM, IS ENSURING ACCESS TO CARE. RECENT PROGRAM EXPANSIONS HAVE BROADENED COVERAGE OF PREGNANT WOMEN AND CHILDREN. THE OMNIBUS RECONCILIATION ACT OF 1986 REQUIRED STATES TO PROVIDE MEDICAID-COVERED PRENATAL CARE SERVICES TO WOMEN WITH FAMILY INCOMES UP TO 133 PERCENT OF THE FEDERAL POVERTY LEVEL AS OF APRIL 1, 1990. STATES WERE ALSO GIVEN THE OPTION TO ADOPT OTHER PROGRAM EXPANSIONS TO INCREASE THE NUMBER OF PEOPLE COVERED AND LENGTH OF TIME THEY ARE COVERED.

STILL, THERE REMAIN MANY BARRIERS TO ACCESS TO CARE FOR MEDICAID RECIPIENTS. FINANCIALLY STRAPPED STATES ARE FINDING IT DIFFICULT TO EXPAND, IMPROVE, OR EVEN MAINTAIN THE DELIVERY OF SERVICES.

BECAUSE OF THIS SUBCOMMITTEE'S CONCERN WITH MEDICAID, YOU ASKED US TO EXAMINE ISSUES RELATED TO ACCESS TO QUALITY HEALTH CARE IN MEDICAID. WE HAVE RECENTLY COMPLETED THREE STUDIES RELATING TO ACCESS TO QUALITY HEALTH CARE FOR MEDICAID RECIPIENTS. I AM PLEASED TO RELEASE OUR REPORTS TO YOU TODAY.

LET ME SUMMARIZE THE RESULTS OF OUR WORK FOR YOU. OUR INSPECTION, "USE OF EMERGENCY ROOMS BY MEDICAID RECIPIENTS" FOUND THAT MEDICAID RECIPIENTS CONTINUE TO UTILIZE EMERGENCY ROOMS (ERs) FOR NON-URGENT CARE LARGELY BECAUSE THEY LACK ACCESS TO PRIMARY HEALTH CARE. ONE REASON THAT RECIPIENTS LACK ACCESS TO CARE IS THAT PHYSICIANS MAY BE RELUCTANT TO PARTICIPATE IN THE PROGRAM. ONE REASON PHYSICIANS MAY NOT PARTICIPATE IN THE MEDICAID PROGRAM IS THE ADMINISTRATIVE BURDEN OR "HASSLE FACTOR" INVOLVED IN SUBMITTING CLAIMS AND RECEIVING PAYMENT. OUR REPORT, "MEDICAID HASSLE: STATE RESPONSES TO PHYSICIAN COMPLAINTS," DISCUSSES NINE APPROACHES THAT STATES HAVE FOUND TO BE RESPONSIVE TO PHYSICIAN COMPLAINTS ABOUT MEDICAID'S ADMINISTRATIVE BURDEN.

ONE MAJOR INITIATIVE BEING IMPLEMENTED BY STATES TO REDUCE INAPPROPRIATE USE OF EMERGENCY ROOMS IS MANAGED CARE OR PRIMARY

CARE CASE MANAGEMENT. THE PRESIDENT IS SUPPORTIVE OF EXPANDING COORDINATED CARE FOR ALL MEDICAID RECIPIENTS. OUR STUDY, ENTITLED "QUALITY ASSURANCE IN MEDICAID HMOs," DISCUSSES THE MECHANISMS THAT STATE MEDICAID AGENCIES HAVE IN PLACE TO ASSURE HIGH QUALITY OF CARE IN MEDICAID HMOs. I WILL NOW DISCUSS THE FINDINGS OF EACH OF THESE THREE REPORTS IN GREATER DETAIL.

NON-URGENT USE OF EMERGENCY ROOMS

THE USE OF EMERGENCY DEPARTMENTS FOR NON-URGENT CARE BY MEDICAID RECIPIENTS HAS LONG BEEN RECOGNIZED BY STATE AND FEDERAL POLICY MAKERS AS A PROBLEM. IN 1983 THE OIG RELEASED A REPORT ON NON-URGENT USE OF ERS BY MEDICAID AND MEDICARE BENEFICIARIES. WE REPORTED THAT MEDICAID RECIPIENTS USE ERs FOR NON-URGENT CARE LARGELY BECAUSE OTHER SOURCES OF CARE ARE EITHER UNAVAILABLE OR INACCESSIBLE TO THEM. WE ESTIMATED THAT AT LEAST HALF OF MEDICAID ER VISITS WERE NON-URGENT AND COULD HAVE BEEN MORE APPROPRIATELY TREATED IN COMMUNITY CARE SETTINGS.

OUR NEW REPORT ON USE OF EMERGENCY ROOMS BY MEDICAID RECIPIENTS ENTITLED, "USE OF EMERGENCY ROOMS BY MEDICAID RECIPIENTS," FOUND THAT NON-URGENT USE OF EMERGENCY ROOMS HAS REMAINED A PROBLEM. WE ESTIMATE THAT OVER ONE-HALF TO TWO-THIRDS OF MEDICAID EMERGENCY ROOM VISITS IN OUR NINE SAMPLE STATES ARE NON-URGENT. OUR STUDY FOUND THAT REDIRECTING PATIENTS TO MORE APPROPRIATE SETTINGS ALLOWS MEDICAID RECIPIENTS TO RECEIVE

BETTER QUALITY CARE. EMERGENCY ROOMS CANNOT PROVIDE THE CONTINUITY OF CARE THAT IS AVAILABLE THROUGH CLINICS OR PHYSICIAN OFFICES DELIVERING ONGOING PRIMARY CARE.

ADDITIONALLY, IF NON-EMERGENCY VISITS WERE REDIRECTED TO MORE APPROPRIATE (AND LESS COSTLY) COMMUNITY CARE SITES, SUBSTANTIAL SAVINGS IN MEDICAID COULD BE REALIZED. IT IS APPROXIMATELY THREE TIMES MORE EXPENSIVE TO ADMINISTER CARE IN AN EMERGENCY ROOM THAN IN A COMMUNITY SETTING. IN THE FOUR STATES FOR WHICH WE HAVE DATA, $39.5 MILLION COULD HAVE BEEN SAVED IN 1990 IF THE NUMBER OF INDIVIDUALS RECEIVING NON-URGENT CARE IN EMERGENCY ROOMS WERE REDUCED, AND THESE INDIVIDUALS WERE REDIRECTED TO CARE IN THE COMMUNITY.

THE USE OF EMERGENCY ROOMS FOR NON-URGENT CARE RESULTS PRIMARILY FROM THE RECIPIENT'S LACK OF ACCESS TO PRIMARY CARE DURING OR AFTER OFFICE HOURS. OFTEN, THE MEDICAID RECIPIENT DOES NOT HAVE A DOCTOR THAT THEY SEE ON A REGULAR BASIS. RECIPIENTS MAY NOT LIVE NEAR A PARTICIPATING PHYSICIAN OR MAY LACK TRANSPORTATION TO GET TO THE PHYSICIAN'S OFFICE. A RECIPIENT MAY NOT BE ABLE TO GO TO A PHYSICIAN'S OFFICE DURING NORMAL OFFICE HOURS, AND MAY HAVE DIFFICULTY REACHING THE PHYSICIAN AFTER HOURS.

HEALTH CARE PROVIDERS MAY EXACERBATE THE PROBLEM BY REFERRING RECIPIENTS TO ERs AFTER OFFICE HOURS, OR VERIFYING THE NEED FOR THIS CARE IN THE ER WHEN CONTACTED BY THE HOSPITAL.

ADDITIONALLY, HOSPITALS DO NOT ALWAYS CONTACT PHYSICIANS FOR AUTHORIZATION BEFORE TREATING PATIENTS ENROLLED IN MANAGED CARE PROGRAMS.

INITIATIVES STATES HAVE IMPLEMENTED TO STEM THE PROBLEM

WE IDENTIFIED A NUMBER OF WAYS THAT STATES IN OUR SAMPLE REDUCE NON-URGENT USE OF EMERGENCY ROOMS. THESE APPROACHES INCLUDE:

- MANAGED CARE
- PRE-PAID PLANS
- 24 HOUR TELEPHONE LINE TO A NURSE
- TIERED PRICING
- TRIAGE FEES
- EMERGENCY ROOM CLAIMS REVIEW
- CO-PAYMENTS
- LOCK-IN OF MEDICAID RECIPIENT

THE APPROACH MOST FREQUENTLY CONSIDERED SUCCESSFUL (BY THE STATES' OWN SELF EVALUATIONS) ADDRESSES ACCESS TO CARE THROUGH MANAGED CARE OR PREPAID PROGRAMS. ONE OF THE PRIMARY FUNCTIONS OF MANAGED CARE/PRE-PAID PLANS IS TO PROVIDE RECIPIENTS WITH AN ONGOING SOURCE OF PRIMARY CARE AND REFERRAL TO OTHER SERVICES. IN THE NINE STATES WE STUDIED, BETWEEN 7 AND 71 PERCENT OF MEDICAID RECIPIENTS ARE CURRENTLY ENROLLED IN SUCH PROGRAMS. GREATER REDUCTIONS IN NON-EMERGENCY VISITS MIGHT BE ACHIEVED IF MORE MEDICAID RECIPIENTS WERE ENROLLED IN MANAGED CARE/PREPAID PROGRAMS. THESE PROGRAMS REQUIRE 24 HOUR PHONE ACCESS TO A

CARE GIVER FOR THE PURPOSE OF PROVIDING AN ASSESSMENT OF THE APPROPRIATE SITE FOR CARE. BY HAVING AN INDIVIDUAL OR GROUP ACT AS A "GATE KEEPER," AND DIRECTING CARE TO THE MOST APPROPRIATE SETTING, THE NUMBER OF NON-URGENT VISITS TO THE EMERGENCY ROOM MAY BE REDUCED.

THE SUCCESS OF STATE INITIATIVES TO CONTROL NON-URGENT USE OF ERs IS DIFFICULT TO DOCUMENT, BUT OUR SAMPLE STATES OFFERED SOME EVIDENCE TO INDICATE THESE CONTROLS HAVE HAD A SALUTARY EFFECT. IN MISSOURI, FOR EXAMPLE, ER VISITS BY INDIVIDUALS ENROLLED IN A MANAGED CARE/PRE-PAID PROGRAM HAVE DECLINED DESPITE AN INCREASE IN ENROLLMENT. IN WISCONSIN AND PENNSYLVANIA, THE PERCENT OF NON-URGENT VISITS FOR MEDICAID RECIPIENTS ENROLLED IN MANAGED CARE IS LOWER THAN THAT OF MEDICAID RECIPIENTS IN THE TRADITIONAL FEE-FOR-SERVICE MEDICAID PROGRAM. FOR THE YEARS 1987 THROUGH 1989, SEVEN STATES HAVE REPORTED SAVINGS OF APPROXIMATELY $182 MILLION FROM MANAGED CARE AND PRE-PAID PROGRAMS WHICH INCLUDED CONTROLS PLACED ON NON-URGENT USE OF ERs. THREE OF THE PROGRAMS HAVE REPORTED SAVINGS OF APPROXIMATELY $13.6 MILLION THAT ARE DIRECTLY ATTRIBUTABLE TO ER CONTROLS.

BASED ON OUR FINDINGS, WE HAVE RECOMMENDED THAT THE HEALTH CARE FINANCING ADMINISTRATION ENCOURAGE STATES TO DEVELOP INITIATIVES TO REVIEW AND REDUCE NON-URGENT USE OF EMERGENCY ROOMS BY MEDICAID RECIPIENTS, ASSIST THEM THROUGH ANALYSIS AND DISSEMINATION OF EFFECTIVE EMERGENCY ROOM CONTROL PRACTICES, AND STREAMLINE THE WAIVER APPLICATION PROCESS FOR CONTROLS AIMED AT REDUCING NON-URGENT ER USE. WE ALSO RECOMMENDED THAT EACH STATE DEVELOP A COMPREHENSIVE INITIATIVE TO REDUCE COSTLY NON-URGENT USE OF EMERGENCY ROOMS. (THE OIG REPORTS, "USE OF EMERGENCY ROOMS BY MEDICAID RECIPIENTS" AND "CONTROLLING EMERGENCY ROOM USE: STATE MEDICAID REPORTS," ARE HEREBY SUBMITTED FOR THE RECORD.)

STATE EFFORTS IN REDUCING MEDICAID ADMINISTRATIVE BURDEN

PHYSICIANS CONTEND THAT THE "HASSLE FACTOR"--ADMINISTRATIVE RED TAPE ASSOCIATED WITH PARTICIPATING IN MEDICAID--DISCOURAGES MANY DOCTORS FROM TREATING PATIENTS WHO ARE COVERED BY MEDICAID. WHEN PROVIDERS REFER TO THE ADMINISTRATIVE BURDEN, THEY GENERALLY ARE REFERRING TO SUCH PROBLEMS AS:

- SLOW PAYMENTS;
- REJECTION OF CLAIMS BECAUSE THE BILLING FORM WAS COMPLETED INCORRECTLY;
- DIFFICULTIES IN CORRECTING CLAIMS THAT CONTAIN ERRORS;
- INABILITY TO VERIFY RECIPIENTS' MEDICAID ELIGIBILITY, LEADING TO CLAIM DENIALS;
- FREQUENT CHANGES IN POLICIES, COVERED PROCEDURES, AND REQUIRED DOCUMENTATION; AND
- CONFUSING PROVIDER MANUALS THAT DO NOT MEET THE NEEDS OF PROGRAM PROVIDERS.

ALTHOUGH THE ADMINISTRATIVE BURDEN APPEARS TO BE AN IMPORTANT

FACTOR IN PHYSICIAN DISSATISFACTION WITH MEDICAID, IT IS CRITICAL TO RECOGNIZE THAT EASING THAT BURDEN ALONE WILL NOT NECESSARILY LEAD TO HIGHER PARTICIPATION RATES. OTHER FACTORS --MOST NOTABLY A LOW LEVEL OF REIMBURSEMENT RELATIVE TO MEDICARE OR PRIVATE INSURANCE--HAVE BEEN IDENTIFIED BY GROUPS SUCH AS THE PHYSICIAN PAYMENT REVIEW COMMISSION AND THE NATIONAL GOVERNORS ASSOCIATION AS MORE IMPORTANT FACTORS AFFECTING MEDICAID PROVIDER PARTICIPATION RATES.

WITH THAT IN MIND, OUR STUDY IDENTIFIED NINE APPROACHES THAT STATES HAVE IMPLEMENTED TO BE RESPONSIVE TO PHYSICIAN COMPLAINTS ABOUT MEDICAID'S ADMINISTRATIVE BURDEN. THE APPROACHES RESPOND TO CRITICISMS ABOUT CLAIMS PROCESSING, COMMUNICATION BETWEEN PHYSICIANS AND MEDICAID AGENCIES, AND PROVIDER MANUALS. TO IDENTIFY THESE APPROACHES, WE INTERVIEWED MEMBERS OF PROFESSIONAL SOCIETIES, HCFA, OTHER RESEARCHERS, AND REVIEWED THE LITERATURE.

IMPROVING CLAIMS PROCESSING

PARTICULAR COMPLAINTS ABOUT CLAIMS PROCESSING CENTER AROUND FRUSTRATION WITH THE PROCESS OF SUBMITTING AND GETTING CLAIMS PAID. FOR EXAMPLE, ONE PHYSICIAN TOLD US THAT, "...EVEN THE MOST INTELLIGENT NEUROSURGEON GETS HUNG UP ON WHAT NEEDS TO BE DONE." ANOTHER, EXPRESSING A COMMON COMPLAINT, SAID, "PHYSICIANS AREN'T GIVEN AN EXPLANATION FOR REJECTED CLAIMS. IT IS THE DOCTOR'S RESPONSIBILITY TO TRACK THE CLAIM AND FIND OUT WHY IT WAS DENIED, WHICH TAKES EXTRA STAFF TIME AND

FINANCIAL RESOURCES."

IN AN ATTEMPT TO ADDRESS THESE TYPES OF COMPLAINTS, AT LEAST 28 STATES HAVE INSTITUTED ELECTRONIC CLAIMS SYSTEMS FOR PHYSICIANS SERVICES. THE PROPORTION OF CLAIMS IN EACH OF THESE STATES THAT ARE SUBMITTED ELECTRONICALLY RANGES FROM 3 PERCENT IN NORTH DAKOTA TO 66 PERCENT IN GEORGIA.

IN FLORIDA, THE MEDICAID AGENCY HAD DEVELOPED SOFTWARE THAT ENABLES ANY PROVIDER TO SUBMIT CLAIMS ELECTRONICALLY. (THE SOFTWARE, AS WELL AS CLAIMS SUBMISSION, IS FREE OF CHARGE TO THE PROVIDER.) USING THE SYSTEM, PHYSICIANS CAN TAILOR THE SOFTWARE TO MEET THEIR PARTICULAR NEEDS WHEN IT IS INSTALLED. FOR EXAMPLE, SOME INFORMATION, SUCH AS THE PHYSICIAN'S NAME AND ADDRESS AND THE DATE OF THE CLAIM, MAY BE AUTOMATICALLY INSERTED EACH TIME A CLAIM IS PREPARED, AND DIAGNOSTIC, PROCEDURE, OR BILLING CODES (FOR COMMON ILLNESSES THAT PHYSICIANS MAY TREAT) CAN BE INSERTED WITH A SINGLE KEYSTROKE.

STAFF AT SEVERAL STATE MEDICAID AGENCIES WE SPOKE WITH STRESSED THEIR COMMITMENT TO ELECTRONIC CLAIMS SUBMISSION. ADVANTAGES OF USING ELECTRONIC CLAIMS SUBMISSION INCLUDE FASTER PAYMENT COMPARED TO SUBMISSION OF PAPER CLAIMS AND REDUCED COST TO THE PROVIDER FOR CLERICAL SERVICES, SINCE PAPERWORK IS DECREASED AND THE PHYSICIAN'S SIGNATURE IS NOT REQUIRED ON EACH CLAIM.

DESPITE THE ADVANTAGES OF ELECTRONIC CLAIMS PROCESSING, MOST

PHYSICIAN CLAIMS ARE STILL SUBMITTED ON PAPER. ONE REASON IS THAT MANY PHYSICIAN OFFICES DO NOT HAVE AVAILABLE THE COMPUTER HARDWARE NECESSARY FOR ELECTRONIC SUBMISSION OF CLAIMS.

SEVERAL STATES HAVE ALSO DEVELOPED AUTOMATED TELEPHONE INQUIRY SYSTEMS TO ANSWER PHYSICIAN INQUIRIES ABOUT CLAIMS STATUS, RECIPIENT ELIGIBILITY, AND OTHER ROUTINE MATTERS. THESE SYSTEMS CAN BE ACCESSED WITH A TOUCH-TONE PHONE. SINCE MOST CALLS TO MEDICAID ARE "ROUTINE," AND CONCERN ELIGIBILITY, CLAIMS STATUS, ETC., THESE CAN BE HANDLED QUICKLY AND SYSTEMATICALLY, FREEING STAFF TO DEAL WITH THE MORE DIFFICULT SITUATIONS AND QUESTIONS. FOR EXAMPLE, MARYLAND'S AUTOMATED VOICE RESPONSE SYSTEM OPERATES CONTINUOUSLY, AND PERMITS PROVIDERS TO VERIFY DATES OF PROGRAM ELIGIBILITY FOR SERVICES RENDERED UP TO ONE YEAR PREVIOUSLY.

STATES HAVE ALSO DEVELOPED TROUBLESHOOTING GUIDES WITH SPECIFIC INSTRUCTIONS ON HOW TO CORRECT COMMON BILLING ERRORS. ADDITIONALLY, TWO STATES (MICHIGAN AND FLORIDA) USE SPECIAL INSTRUCTORS TO TRAIN PHYSICIAN OFFICE STAFF ABOUT MEDICAID BILLING AND POLICY.

IMPROVING COMMUNICATIONS BETWEEN PHYSICIANS AND MEDICAID

PHYSICIANS HAVE COMPLAINED THAT POLICIES ARE MADE IN MEDICAID WITH LITTLE INPUT FROM PRACTICING PHYSICIANS. OUR STUDY FOUND THAT IN THREE STATES (WASHINGTON, ALABAMA, AND MISSOURI), INVOLVING PHYSICIANS IN TASK FORCES TO SOLVE MEDICAID "RED-

TAPE" PROBLEMS YIELDED MUTUAL BENEFITS. FOR EXAMPLE, AS A RESULT OF WASHINGTON'S "RED TAPE TASK FORCE," MEDICAID ESTABLISHED FIELD UNITS TO GIVE TECHNICAL ASSISTANCE TO PHYSICIANS AND IDENTIFIED ACCEPTABLE DOCUMENTS TO CONFIRM THAT A RECIPIENT LACKS PRIVATE THIRD PARTY INSURANCE COVERAGE; ALABAMA'S PHYSICIAN TASK FORCE LED TO THE CREATION OF SHORTER SCREENING FORMS FOR THE EARLY PERIODIC SCREENING, DIAGNOSIS, AND TESTING PROGRAM; AND MISSOURI'S TASK FORCE IMPLEMENTED A SYSTEM TO INCREASE THE NUMBER OF CLAIM ERRORS THAT ARE IDENTIFIED DURING THE FIRST PROCESSING RUN SO THAT THE SAME CLAIM IS NOT REJECTED MULTIPLE TIMES. IN GENERAL, THESE PARTNERSHIPS HELP MEDICAID PROGRAM STAFF GAIN A BETTER UNDERSTANDING OF THE "REAL WORLD" IN WHICH PHYSICIANS PRACTICE, AND EDUCATE PHYSICIANS ABOUT THE CONSTRAINTS UNDER WHICH THE MEDICAID PROGRAM OPERATES.

IMPROVING PROVIDER MANUALS

FOLLOWING PROVIDER COMPLAINTS ABOUT COMPLICATED AND EVER-CHANGING MANUALS IN MEDICAID, SOME STATES HAVE BEGUN TO SIMPLIFY THEIR MEDICAID MANUALS, OFTEN UTILIZING INPUT FROM THE PHYSICIANS FOR THE REVISIONS. MICHIGAN HAS BEGUN MANUAL REVISIONS BASED ON SURVEYS AND DISCUSSIONS WITH BILLING STAFF IN PHYSICIAN OFFICES. THE NEW MANUALS WILL BE EASIER TO USE AND UNDERSTAND BY UTILIZING GRAPHICS, REFERENCE INDEXES, AND CONCISE LANGUAGE. UNFORTUNATELY, THIS INITIATIVE HAS BEEN PLACED ON HOLD DUE TO BUDGET CONSTRAINTS.

MARYLAND HAS DEVELOPED, AND DISTRIBUTES TO PROVIDERS, TWO MANUALS FOR PROVIDERS IN ITS "HEALTHY KIDS INITIATIVE" TO SIMPLIFY THE BILLING PROCESS AND EXPLAIN RECOMMENDED PEDIATRIC SCREENING SCHEDULES AND TESTS.

WHEN CONSIDERING THE POTENTIAL IMPACT OF THESE APPROACHES AND THEIR APPLICABILITY IN OTHER STATES, IT IS IMPORTANT TO TAKE INTO ACCOUNT STATE AND FEDERAL NEEDS FOR FISCAL ACCOUNTABILITY. THESE NEEDS MEAN THAT SOME TENSION BETWEEN MEDICAID'S ADMINISTRATIVE REQUIREMENTS AND WHAT PROVIDERS PERCEIVE AS HASSLE IS UNAVOIDABLE. (THE OIG REPORT, "MEDICAID HASSLE: STATE RESPONSES TO PHYSICIAN COMPLAINTS," IS HEREBY SUBMITTED FOR THE RECORD.)

QUALITY ASSURANCE IN MEDICAID HMOs

STATES HAVE TURNED TO MANAGED CARE AS THEIR BEST ALTERNATIVE TO ENSURE ACCESS AND CONTINUITY OF CARE. IT IS ESPECIALLY IMPORTANT TO HAVE QUALITY ASSURANCE (QA) SYSTEMS IN PLACE BECAUSE THE CAPITATED PAYMENT ARRANGEMENT IN MANAGED CARE SYSTEMS MAY CREATE A FINANCIAL INCENTIVE TO UNDERTREAT. CURRENTLY, QUALITY IS ENSURED IN MANAGED CARE SETTINGS MAINLY BY STANDARDS IMPOSED BY STATE MEDICAID AGENCIES.

IN OUR STUDY, "QUALITY ASSURANCE IN MEDICAID HMOs," WE EXAMINED THE STANDARDS THAT MEDICAID AGENCIES HAVE IN PLACE TO ENSURE QUALITY. WE INTERVIEWED ALL 25 MEDICAID AGENCIES THAT CONTRACT

WITH HEALTH MAINTENANCE ORGANIZATIONS (HMOs) TO PROVIDE MEDICAL CARE. WE IDENTIFIED 13 KEY STANDARDS THAT ENCOMPASSED ALL OF THE QA STANDARDS "ENDORSED" BY THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE'S QA STANDARDS, THE NATIONAL ASSOCIATION OF HMO REGULATORS/NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS' RECOMMENDED OPERATIONAL REQUIREMENTS FOR HMO QA PROGRAMS, AND THE HEALTH CARE FINANCING ADMINISTRATION.

FOR PURPOSES OF OUR STUDY, WE DIVIDE QUALITY ASSURANCE STANDARDS INTO THREE MAJOR CATEGORIES: STRUCTURE, PROCESS, AND OUTCOME. STRUCTURAL STANDARDS PROVIDE AN ASSESSMENT OF THE NATURE OF AN HMO's HEALTH CARE RESOURCES, SUCH AS ITS FACILITY, STAFF, AND THE RULES OF PROCEDURE. PROCESS STANDARDS ASSESS THE INTERMEDIATE PRODUCTS OF CARE, SUCH AS UTILIZATION RATE, CHOICE OF THERAPIES, PHYSICIAN CREDENTIALING, AND EFFECTIVENESS OF PROCEDURES. OUTCOME STANDARDS FOCUS ON THE NET RESULTS OF CARE.

OVERALL, THE NUMBER OF THE 13 STANDARDS THAT STATES REQUIRE RANGES FROM A MINIMUM OF 4 (IN HAWAII AND UTAH) TO 12 STANDARDS (IOWA). THE EXCLUSION OF SOME STANDARDS BY MEDICAID AGENCIES DOES NOT NECESSARILY INDICATE THAT THE AGENCY VIEWS THEM AS UNNECESSARY. INSTEAD THEY MAY VIEW PARTICULAR QA FUNCTIONS AS INHERENT IN THE HMO PHILOSOPHY, AND SEE THE INCLUSION OF SOME STANDARDS AS DUPLICATIVE OF OTHER REQUIREMENTS. IN FACT, MANY QUALITY ASSURANCE STANDARDS ARE SIMPLY GOOD BUSINESS PRACTICE. THIS MAY EXPLAIN WHY MOST OF THE HMOs WE INTERVIEWED ADOPTED QA

STANDARDS EVEN WHEN NOT REQUIRED BY THE MEDICAID AGENCY. (THE OIG REPORT, "QUALITY ASSURANCE IN MEDICAID HMOs," IS HEREBY SUBMITTED FOR THE RECORD.)

ALL MEDICAID AGENCIES USE SOME FORM OF STRUCTURAL STANDARDS. STRUCTURAL STANDARDS PROVIDE AN ASSESSMENT OF THE NATURE OF AN HMO's HEALTH CARE RESOURCES--ITS FACILITY, STAFF, AND THE RULES OF PROCEDURE. WE ASKED MEDICAID AGENCIES ABOUT THREE STRUCTURAL STANDARDS: PATIENT EDUCATION PROGRAMS, ACCESS TO CARE, AND HAVING A WRITTEN QUALITY ASSURANCE PLAN. FEDERAL LAW MANDATES TWO OF THESE STANDARDS: FEDERAL AND STATE LAWS REQUIRE HMOs TO SUBMIT MARKETING PLANS, PROCEDURES, AND OTHER MATERIALS TO THE MEDICAID AGENCY FOR APPROVAL, AND PATIENT EDUCATION MATERIALS IS CONVEYED TO MEDICAID RECIPIENTS PRIMARILY THROUGH HMO MARKETING MATERIALS. MEDICAID AGENCIES ARE ALSO REQUIRED TO PROVIDE ACCESS TO CARE AT ALL TIMES.

- ALL 25 MEDICAID AGENCIES REQUIRE HMOs TO HAVE PATIENT EDUCATION PROGRAMS; SOME WORK VERY CLOSELY WITH THEIR HMOs TO DEVELOP EDUCATIONAL MATERIALS ON PATIENT BENEFITS, RIGHTS, AND RESPONSIBILITIES.
- ALL 25 MEDICAID AGENCIES REQUIRE HMOs TO PROVIDE ACCESS TO CARE USING A VARIETY OF METHODS.
- 23 MEDICAID AGENCIES REQUIRE THEIR HMOs TO DEVELOP A WRITTEN QUALITY ASSURANCE PLAN.

MEDICAID AGENCIES HAVE CARRIED OVER MANY FEE-FOR-SERVICE PROCESS STANDARDS TO THEIR HMO PROGRAM. PROCESS STANDARDS ASSESS THE INTERMEDIATE PRODUCTS OF CARE SUCH AS UTILIZATION

RATES, CHOICE OF THERAPIES, AND EFFECTIVENESS OF PROCEDURES. THESE STANDARDS ARE USED BY HMOs TO MINIMIZE EXPOSURE FROM UNQUALIFIED HEALTH PRACTITIONERS, MONITOR RESOURCE CONSUMPTION, ASSESS ADHERENCE TO HMO STANDARDS OF PRACTICE, AND MANAGE THEIR CARE NETWORK AND PROVIDER BEHAVIOR.

- 21 AGENCIES REQUIRE HMOS TO VERIFY THAT PHYSICIANS ARE PROPERLY CREDENTIALED.
- 16 MEDICAID AGENCIES REQUIRE HMOs TO COLLECT INDIVIDUAL PATIENT CARE DATA.
- 13 AGENCIES REQUIRE HMOs TO USE THE DATA FOR INTERNAL UTILIZATION REVIEW PROGRAMS.
- ALL MEDICAID AGENCIES CONDUCT EPISODIC MEDICAL RECORD REVIEWS; 12 REQUIRE HMOs TO CONDUCT THEIR OWN MEDICAL RECORD REVIEWS.
- SEVEN AGENCIES REQUIRE HMOs TO REPORT TO THEM, OR OTHER APPROPRIATE AUTHORITIES, SERIOUS QUALITY PROBLEMS RESULTING IN A PHYSICIANS' SUSPENSION OR TERMINATION.
- SIX MEDICAID AGENCIES REQUIRE THE USE OF CLINICAL PRACTICE GUIDELINES ESTABLISHING MINIMUM STANDARDS OF CARE.
- THREE AGENCIES REQUIRE HMOs TO "MANAGE" PHYSICIAN BEHAVIOR IN SOME WAY. AGENCIES MANAGE BY PROVIDING EDUCATION AND FEEDBACK ON PRACTICE PATTERNS IN COMPARISON WITH OTHER HMO PHYSICIANS, PROVIDING HMO PROFIT SHARING IF THE PROVIDER MEETS CERTAIN STANDARDS OR GOALS, AND OTHER MANAGEMENT TECHNIQUES.

MEDICAID AGENCIES RELY ON COMPLAINT STANDARDS MORE THAN PATIENT SATISFACTION SURVEYS AND HEALTH OUTCOME REVIEWS TO ENSURE QUALITY. ASSESSING ADHERENCE TO OUTCOME STANDARDS IS USUALLY LEFT TO THE HMO.

- ALL 25 STATES REQUIRE THE HMOs TO HAVE COMPLAINT OR

GRIEVANCE PROCEDURES IN PLACE AS REQUIRED BY FEDERAL LAW. FIVE MEDICAID AGENCIES OPERATE THEIR OWN COMPLAINT AND GRIEVANCE UNITS.

- EIGHT STATES REQUIRE HMOs TO CONDUCT PATIENT SATISFACTION SURVEYS. SEVEN MEDICAID AGENCIES CONDUCT THEIR OWN INDEPENDENT SURVEYS TO ASSESS RECIPIENT SATISFACTION.
- SIX MEDICAID AGENCIES REQUIRE HMOs TO MONITOR AND EVALUATE THE HEALTH OUTCOMES OF THEIR MEDICAID PATIENTS. WE FOUND NO STATE CONDUCTING ITS OWN INDEPENDENT OUTCOME REVIEWS.

CONCLUSION

POLICY ALTERNATIVES TO INCREASE ACCESS MUST BE CONSIDERED IN THE CONTEXT OF BUDGETARY AND OTHER CONSTRAINTS FACED BY THE STATES AND THE FEDERAL GOVERNMENT. CERTAINLY ADDITIONAL WORK IS NEEDED. WE LOOK FORWARD TO WORKING WITH THE COMMITTEE, THE STATES, AND HCFA IN THIS IMPORTANT AREA. THIS CONCLUDES MY PREPARED TESTIMONY. I WOULD BE HAPPY TO ANSWER ANY QUESTIONS THE COMMITTEE MIGHT HAVE.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

USE OF EMERGENCY ROOMS BY MEDICAID RECIPIENTS

Richard P. Kusserow
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OEI 06-90-00180

EXECUTIVE SUMMARY

PURPOSE

This report describes programs or procedures developed by nine States to control the non-emergency use of emergency rooms by Medicaid recipients and evidence of their success.

BACKGROUND

During the last decade, Medicaid agencies have felt the financial pinch of program expansions and rising costs. Medicaid Programs have sought to control program costs through various means while maintaining quality care. One method has been tighter controls on the use of Medicaid services, including hospital emergency rooms.

The non-emergency use of emergency rooms by Medicaid recipients has long been recognized as a problem. In September 1983 the OIG released a report (OAI-"Non-emergency Use of Hospital Emergency Departments by Medicaid and Medicare Beneficiaries") which found a very high misuse of hospital emergency rooms by Medicaid recipients. Studies continue to show that Medicaid recipients consistently make a higher proportion of non-emergency and marginally appropriate emergency room visits ranging from 17 percent to 61 percent. In contrast, recent studies show non-emergency visits for the general public range between 11 percent to 38 percent of all emergency room visits. These findings indicate significant potential for containing costs and improving the quality of care through reducing non-emergency utilization and redirecting recipients to more appropriate care sites.

We interviewed 17 Medicaid directors and managers in nine different States about the programs/procedures they have established to control non-emergency use of the emergency room, their motivations for development, and their perceived and actual success. In addition we obtained utilization and charge data from the States and the Medicaid Statistical Information System (MSIS) program at the Health Care Financing Administration (HCFA). States were selected on the basis that they had "mature" controls in place. Mature was defined by length of establishment, comprehensiveness and/or likelihood of having cost and utilization data available.

FINDINGS

Heavy Non-Emergency Use of Emergency Rooms By Medicaid Recipients Is A Continuing Problem.

- *Over one-half to two-thirds of Medicaid emergency room visits are non-emergency.*

Substantial Medicaid Savings Could Be Realized By Redirecting Non-emergency Visits To More Appropriate And Less Costly Care Sites.

States Developed Controls To Improve Access And Continuity Of Care, As Well As To Reduce Costs.

States in our sample had developed 23 programs/procedures to control non-emergency utilization of the emergency room. These include:

Managed Care
Co-payment
Emergency Room Claims Review
Pre-paid Health Plans
Lock-in
Emergency Room Visit Limit
Payment Differentiation
Other (Nurse Phone Line)

The Majority Of Programs/Procedures Considered Successful Address Access To Care Through Managed Care/Pre-paid Programs.

States Have Been Successful In Overcoming Opposition To Controls On Non-Emergency Use Of Emergency Rooms.

Despite The Positive Actions Taken By Study States, Non-Emergency Use Of Emergency Rooms Is Still A Problem.

RECOMMENDATIONS

Each State should develop a comprehensive initiative to reduce costly non-emergency use of emergency rooms.

The HCFA should encourage States to develop initiatives to review and reduce non-emergency use of emergency rooms by Medicaid recipients and assist them through data analysis instructions, expedited review of waiver applications for managed care and dissemination of effective emergency room control practices.

AGENCY COMMENTS

We received comments from the Health Care Financing Administration (HCFA) and the Public Health Service (PHS). HCFA concurred with the parts of the recommendations related to the increased use of managed care for Medicaid recipients and expediting the review of State applications for waivers to implement managed care efforts and emergency room controls. They stated that the President's proposed Comprehensive Health Care Program would go beyond our first recommendation. Further, they stated they had implemented a streamlined Waiver Application in November 1991. Because of the President's proposed initiative, HCFA did not believe the remaining portions of the first recommendation were necessary. In addition, the HCFA believes providing specific instructions on accessing and using ER data for annual reviews of utilization would require extensive research. The HCFA also provided technical comments pertaining to the methodology used to estimate program savings and savings to society which could result from redirecting Medicaid recipients to community care facilities. (See Appendix G for the full text of the HCFA comments.)

The PHS acknowledged the relevance of the general findings that (1) lack of access to primary care is a major cause of inappropriate usage of the emergency room and (2) access to alternate care is an important component in developing effective control of emergency room use. However, they felt more discussion of problems facing Medicaid recipients in gaining access to more appropriate care would have been helpful. PHS also expressed concern about our use of the word "inappropriate." (See Appendix G for the full text of the PHS comments.)

OIG RESPONSE

The OIG believes the use of a comprehensive coordinated care system by Medicaid, which includes case management, is an excellent proposal and will address both access and non-emergency use of the emergency room. However, we feel that the remaining components of the first recommendation complement this initiative and will help States initiate and maintain a decrease in non-emergency use of the emergency room. The OIG also believes that providing guidance on access and use of emergency room data for annual review is important and would not require extensive research, as many States appear to have data on emergency room visits available. Based on HCFA comments the wording of the second recommendation was changed from "require" to "encourage". In response to technical comments, clarifications were made on the assumptions underlying our methodology and our approach for calculating savings to society.

The PHS comments were considered and resulted in clarifications within the report. With regard to access to alternate care, we agree that this is an important issue warranting continued study. However, this is a broad subject and beyond the scope of this inspection. We agree that it is difficult to define the appropriateness of emergency room visits. However, the focus of this inspection was narrower, examining only non-emergency care. Hence, we changed the word "inappropriate" to "non-emergency" in the few places it was used in this report.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID HASSLE: STATE RESPONSES TO PHYSICIAN COMPLAINTS

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OEI-01-92-00100

EXECUTIVE SUMMARY

PURPOSE

This study describes approaches that States have taken in response to concerns about Medicaid's administrative burden on physicians.

BACKGROUND

Physicians contend that the "hassle factor"--administrative red tape associated with participating in Medicaid--discourages many doctors from treating patients who are covered by Medicaid. The perceived hassle compounds other factors contributing to low physician participation, most notably low fees relative to other payers. When physicians refer to the administrative burden, they generally mean such problems as

- Slow payments;
- Rejection of claims because the billing form was completed incorrectly;
- Difficulties in correcting claims that contain errors;
- Inability to verify recipients' Medicaid eligibility, leading to claim denials;
- Frequent changes in policies, covered procedures, and required documentation;
- Obtuse provider manuals that do not meet the needs of program providers.

We identified States that are working to reduce Medicaid hassle through interviews with officials of national and State medical societies, staff of the Health Care Financing Administration, policy analysts familiar with State health issues, and a review of the literature on Medicaid physician participation. We then interviewed staff from the Medicaid program, fiscal agent, and medical society in these States, and reviewed available written material. We also examined data from an OIG survey of State Medicaid electronic claims management capacity, conducted in spring 1991.

FINDINGS

We identified nine approaches that States have found to be responsive to physician complaints about Medicaid's administrative burden. They respond to criticisms about claims processing, communication between physicians and Medicaid agencies, and provider manuals.

Improving Claims Processing

- At least 28 States accept electronic claims for physician services.

- At least 21 States use automated systems to answer physician inquiries about claims status, recipient eligibility, and other routine matters.

- Maryland and Florida give physicians written guides that provide clear instructions on how to correct problem claims.

- Michigan and Florida use specialized programs and instructors to train physician office staff about Medicaid billing and policy.

Improving Communication between Physicians and Medicaid

- Washington, Alabama, and Missouri established joint Medicaid-physician task forces to identify and resolve administrative obstacles to physician participation.

- Florida uses its district Medicaid offices as provider relations units and participates in activities of State and local medical societies.

- Maryland employs a team of consultant nurses to enroll physicians for pediatric care and to assist them with administrative issues.

Simplifying Provider Manuals

- Michigan is revising its provider manuals to make them more understandable to physicians and their staffs.

- Maryland distributes manuals for pediatric screening services that simplify the billing process and explain recommended screening schedules and tests.

CONCLUSIONS

On the basis of the reports from State government and State medical society officials, each of these approaches appears to have potential as a constructive response to physician complaints about Medicaid hassle. In weighing the potential impact of these approaches and their applicability elsewhere, it is important to take the following three considerations into account:

- State and Federal requirements for financial accountability mean that some tension between Medicaid's administrative requirements and what providers perceive as hassle is unavoidable.

- Other policy initiatives, such as higher fees and development of managed care systems, often accompany efforts to reduce Medicaid's administrative burden.

- Fiscal constraints facing State governments limit the extent to which Medicaid programs can implement strategies to reduce the administrative burden.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

DRAFT

QUALITY ASSURANCE IN MEDICAID HMOs

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OEI-05-92-00110

EXECUTIVE SUMMARY

PURPOSE: To describe the quality assurance (QA) standards used by Medicaid agencies to minimize the risk of inappropriate medical care in health maintenance organizations (HMOs).

BACKGROUND: The Federal Government has encouraged the use of "managed care" or "coordinated care" systems, such as HMOs, by Medicaid agencies to curb rising expenditures in these programs. Managed care systems reduce health care expenditures through a combination of preventative health care measures and by monitoring, and to some extent controlling, the medical utilization of both provider and patient. As of June 30, 1991, approximately 5 percent of Medicaid recipients are enrolled in HMOs.

The extent to which an HMO can control utilization and costs, may mean the difference between its financial success or failure. Consequently, the incentives for these providers to limit services makes QA an essential component of managed care programs. Realizing this, Medicaid agencies mandate their contracting HMOs to perform certain QA functions to ensure that Medicaid recipients receive appropriate and good quality care.

In Fiscal Year (FY) 1992, Medicaid programs will spend an estimated $127 billion for medical care. Almost $72.5 billion of this amount will come from Federal matching funds. The Federal share for FY 1993 is projected to be $84.5 billion, a 16.5 percent increase over FY 1992 outlays.

METHODOLOGY: We interviewed Medicaid officials in 24 States and the District of Columbia concerning the QA functions their contracting HMOs are required to perform. Information and documentation was obtained on how Medicaid agencies verify HMO compliance with their QA standards. Additional corroborating evidence on Medicaid agency compliance procedures was obtained from structured interviews with 28 HMOs.

FINDINGS:

THE THREE TYPES OF STANDARDS MEDICAID AGENCIES EMPLOY TO ENSURE QUALITY HMO SERVICES ARE: STRUCTURAL, PROCESS AND OUTCOME.

ALL MEDICAID AGENCIES USE SOME FORM OF STRUCTURAL STANDARDS.

- Structural standards enable Medicaid agencies to assess HMO procedures for: educating patients, providing access to care, and oversight of HMO providers.

Table 1

STRUCTURAL STANDARDS	# of MEDICAID AGENCIES
Patient Education Programs *	25
Access to Care *	25
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MEDICAID AGENCIES HAVE CARRIED OVER FEE-FOR-SERVICE PROCESS STANDARDS TO THEIR HMO PROGRAM.

- Credentialing, utilization review, medical record review and other process standards that parallel Medicaid fee-for-service experience have been readily accepted by Medicaid agencies as good managed care QA standards. However, most process standards do not, in themselves, answer questions about quality of care or patient satisfaction.

MEDICAID AGENCIES RELY ON COMPLAINT STANDARDS MORE THAN PATIENT SATISFACTION SURVEYS AND HEALTH OUTCOME REVIEWS TO ENSURE QUALITY. ASSESSING ADHERENCE TO OUTCOME STANDARDS IS USUALLY LEFT TO THE HMO.

- Outcome standards assess the end products of care and provide a better measure of quality and patient satisfaction than do structural or process standards. Implementation of these standards, which provide the most information on quality and patient satisfaction, have been predominantly left to HMOs. Few Medicaid agencies conduct their own independent assessment of these standards.

Mr. **Rowland**. Thank you very much. Yes, there are some questions that I want to ask you.

Could Medicaid save if care were redirected to more appropriate community care sites than emergency rooms?

Mr. **Mangano**. Absolutely. As I mentioned earlier, care in an emergency room costs about three times as much as care in a local community. We did some estimates.

With four of the States that we were able to come up with accurate information as to their emergency room use, we just assumed that if we could reduce the numbers of emergency room use by Medicaid beneficiaries that were above what the national norm was—the national norm for patients going to an emergency room when they really didn't have to go there was 40 percent—if we could reduce the Medicaid beneficiary rate to 40 percent and still pay the highest rate that was available in those four States for private physician services, which I think was $24.75, we could save in 1 year $39.5 million.

So if you began applying that to all States, substantial savings could be realized.

Mr. **Rowland**. Is there any reason to believe that the emergency room use is different in other States than the four that you mentioned?

Mr. **Mangano**. Well, of course, we only looked at nine States in doing this study, but on the basis of our prior work, the work we did in 1983, and intervening work that touched on this area, we believe that it's consistent across the country.

Mr. **Rowland**. Then, curbing unnecessary use of emergency rooms could run into savings of hundreds of millions of dollars?

Mr. **Mangano**. Well, if we found savings in four States that were equal to $39.5 million, I think it would be a reasonable assumption that there is a lot of money out there to be saved.

Mr. **Rowland**. What's the level of non-emergency use of the emergency rooms overall?

Mr. **Mangano**. There are a variety of studies that speak to that issue. They seem to range between 11 and 38 percent. In making the calculations that we did for this report, we took a very conservative figure and used 40 percent.

Mr. **Rowland**. Many of the Medicaid patients that use emergency rooms do so because they don't have access to care elsewhere, or is it because it's more convenient or for some other reasons?

Mr. **Mangano**. The primary reason that we found was that the Medicaid beneficiaries did not have an ongoing relationship with a private physician. They had nowhere else to go, and that could be during office hours where they did not have an ongoing relationship with a physician, or after hours.

There were some other reasons that tracked into that also—lack of transportation, physicians—those who did have a physician, sometimes, the physician would refer them to the emergency room or verify to the emergency room when the emergency room would call the private physician, that they really needed to be in the emergency room.

But the short answer to your question is, they did not have ongoing relationships with primary care physicians.

Mr. ROWLAND. Was that because they didn't try to establish those relationships, or because the physicians did not accept Medicaid patients? What thoughts do you have on that?

Mr. MANGANO. We weren't able to ask that particular question, but we do have some notions on it. Probably the most important reason—while we talk a little bit later about the hassle factor in Medicaid, studies that have been done by the Physician Payment Review Commission, the National Governors Association, point to the foremost reason why physicians don't participate in Medicaid is the low reimbursement level. The secondary reason is the concern about medical malpractice, and the hassle factor seems to come in about third place there.

So, I think there are a number of reasons why physicians don't participate actively in the program.

Mr. ROWLAND. Emergency room care, it seems to me, would not be very good for ordinary types of care because there's no followup. It's just a one-shot proposition. Do you find that to be true, that they don't——

Mr. MANGANO. Absolutely. We think that, listening to Governor Chiles, there's a real need to have people in an ongoing relationship with primary care physicians. We just have to ensure that. The quality of care that is in the emergency room, we don't find that the quality of the care that was delivered is a problem. In fact, most emergency rooms in this country deliver outstanding care, but there's no continuity to it.

Mr. ROWLAND. Let me go to another area. I talk still with many physicians, and we hear from a lot of them. They talk about the paperwork, the red tape, the burden that they have to deal with, the hassle. Many of them say they have to hire so many more people that it increases the cost of care. Can you tell me what you are referring to when you say administrative burden?

Mr. MANGANO. OK, there are a number of things. One would be slow payments. The second would be the rejection of claims for seemingly minor errors, getting those claims corrected, once they've been identified as being problematic, an inability of the physician to identify a beneficiary as being eligible for Medicaid, frequent changes in State Medicaid procedures and documentation, and some of what we would call obtuse manuals delivered by the States to the physicians that explain how the Medicaid program operates.

Mr. ROWLAND. What about Federal regulations? You know, we tried to address that in our anti-hassle legislation. Is that imposing a burden as well?

Mr. MANGANO. Well, the Medicaid program—there is no one Medicaid program. There's one in every State. States have a lot of flexibility in terms of how they establish their procedures for Medicaid, what the intensity of the services can be, what they'll reimburse for the services, and the mechanisms that are generally in place to ensure that physicians are reimbursed adequately.

I think more of the problem relates to the States as it is a State-administered program.

Mr. ROWLAND. Let me tell you something that I hear in talking with doctors and talking with politicians in my own State of Georgia. The people in political office there say, well, we have to do this because the Federal Government causes us to have to do this.

What about oversight of the Federal Government in this program? Is it true that a lot of the hassle comes about because States have to comply with what the Federal Government requires?

Mr. MANGANO. Well, I think the way I'd answer that would be in the following way: There's always going to be an inherent tension between the physician community and the State as well as Federal Government, because the program does use public funds. Because there needs to be an accountability for those funds, both required by the Federal level as well as the State, there are going to be requirements that could be considered a hassle.

The tracking of those public funds needs to be secure, so I think maybe that's what they're getting at.

Mr. ROWLAND. Well, some physicians say they just don't take Medicaid patients because they think this hassle factor is a real problem. What did your study show on that?

Mr. MANGANO. Well, that certainly is a reason, and our study found that, as well as other studies, but there's also some interesting information we came across. For example, the College of Obstetricians and Gynecologists, in a report that they had released, said, you know, that's probably a problem that existed more in the past than it did today.

In the States that we went to, we came across an interesting log that's kept by the Texas Medical Association, and what that log shows is—they call it their "Hassle Log"—and they show fewer complaints from physicians for Medicaid than they do for Medicare, Workmen's Compensation or Aetna Insurance, which is the third largest insurer in the State of Texas. So, I clearly believe there are hassles that prevent physicians from participating, but we need to look at a more balanced view of that.

Mr. ROWLAND. Is there any racial bias they think might play a part in physicians not accepting Medicaid patients?

Mr. MANGANO. That's possible, but our study would not have looked at that. What I would say is that when physicians sign up for the Medicaid program, they will be approved by the State, but that doesn't necessarily mean that a physician will take a Medicaid beneficiary into his office and treat him. There is some discretion given to physicians as to numbers of people they will take, so there may be some racial bias there. We didn't identify it, but it's possible.

Mr. ROWLAND. One thing that we hear is that there's a reluctance to take Medicaid patients because of the malpractice threat that exists there. I hear this from physicians. What does your study show?

Mr. MANGANO. We know that that is an issue. In another study that we had done, looking at community health centers, we came across some interesting information. The Community Health Centers Program that's operated by the Department of Health and Human Services, delivers direct health care to local communities.

One of the problems that was focused on there was the problem of malpractice insurance also. We came across, in doing our research for that study, some interesting statistics. That is that those community health centers which do take in a substantial number of Medicaid beneficiaries and beneficiaries that are just above that level, their rate of being sued by both population groups was lower than what the national average was for suits.

So, I think—my gut tells me that there's definitely a concern about medical malpractice, but I suspect that the facts wouldn't bear that out in reality.

Mr. ROWLAND. Well, do the doctors have trouble getting insurance anyway based on——

Mr. MANGANO. Oh, sure. No one would dispute the fact that physicians pay very high amounts for premiums for malpractice insurance, and the perception out there is that rates are going to be going up. And the perception out there is that Medicaid beneficiaries do sue more.

Mr. ROWLAND. You have already mentioned the low Medicaid fees and that raising the fees might increase the number of doctors that would take Medicaid patients.

I understand Kentucky has a plan called KenPac that pays physicians an additional $3 for each Medicaid patient that they see.

The report suggests that many doctors are content with this somewhat meager increase. Does that tell us anything about Medicaid fees?

Mr. MANGANO. Medicaid fees are very low. The State of Florida, since that was one of the topics of the early speaker, has made a very strong initiative to raise their Medicaid fees and have now reached, I believe, the 47th percentile of Medicare fees for the Medicaid program.

States do not pay a lot of money for Medicaid, and that continues to be a problem. That is probably the single most important reason why physicians do not participate in Medicaid.

Mr. ROWLAND. In Medicaid.

Mr. MANGANO. That is correct.

Mr. ROWLAND. Well, your report talked about the success in several States that was encouraging physicians to take Medicaid patients by involving physicians more in the decisionmaking process.

That is one thing that I have heard in the past, and as you know, we have put a panel in place with our anti-hassle legislation to talk with HCFA about that, and to my knowledge, that panel has not functioned at all yet.

Have the appointments been made to that panel?

Mr. MANGANO. You are talking about the panel that HCFA intends to operate?

Mr. ROWLAND. I am talking about the long-term panel, not the panel that just exists for a year.

Mr. MANGANO. I am not up to speed on that, but what I can tell you is that, in those States where partnerships have been established between the medical community and the Medicaid agency, we have seen some very strong positive results out of that.

It gives the State Medicaid agencies an opportunity to see life in the real world of the physician, and it gives the physician an opportunity to see what some of the accountability and other kinds of problems the State Medicaid agencies have.

Our report indicates—suggests a number of outcomes that have been very positive that have come out of the States of Washington, Missouri, and Alabama, where they were some of the prime movers in establishing, as one example of that, the automated telephone inquiry system, which allows physicians to call in to get immediate results in terms of the Medicaid beneficiary's eligibility or claim status and the like.

So, there are a number of positive things that have come out of those partnerships.

Mr. Rowland. What you are saying to me, I believe, is that a lot of the decisions made relative to Medicaid regulations have been made in a vacuum, with little attention being given to the day-to-day realities of practicing medicine.

Mr. Mangano. I think far more interplay needs to occur at the State level between the physician community and the Medicaid agencies, and both have a stake in seeing that that happens, because more physicians will join the program as they view it as being a fair and open program, and the beneficiaries are going to be the ultimate winners in that case.

Mr. Rowland. We have heard a little bit about the electronic claims submission. Has that reduced any cost? Does it decrease errors? Do doctors get paid quicker?

Mr. Mangano. Yes, I think it does all of those things. We have been very happy with that. Twenty-eight States now have that. Florida has sort of a model system in which they developed the computer software to do this and made that available free of charge to the physicians in their State. What it enables them to do is to electronically transfer their—submit their claim for reimbursement.

It eliminates a lot of time on the billing staff in the physician's office, because they can sit down at a computer terminal, call up the program, and the program will immediately put onto the claim forms basic identifying information that would have to be put in by hand every time if they did not have that system. They have developed—a single keystroke can put in there what the diagnosis was and what the billing code would be. There is an immediate transfer of that claim into the Medicaid agency for reimbursement, and clerical costs are down because of that.

Mr. Rowland. Your report cited the great complexity, the volume of Medicaid regulations, the manuals and a lot of things that physicians have to comply with that just discourage them from taking Medicaid patients.

I understand that there are a number of initiatives that have been put in place, and one of those is a hotline that a doctor could call and get answers regarding questions.

I hear from some doctors who have had access to lines like that that they call and they cannot get through, and when they do get through, they are put on hold and left there for long periods of time.

Can you tell me a little bit about how well these lines seem to be working?

Mr. Mangano. Sure. The best lines are the lines where a physician can call in and use a touch-tone system and get into the system that way, so that they do not have the—the calls are channeled very quickly to the point at which a response can be given. In those States that we went to, those kinds of hotlines seem to be working very well.

In every State that we went to, we visited the State medical association and talked with them about the initiatives that were going on in those States, and the medical associations were the first to tell us that those were one of the best improvements that they had seen in the Medicaid program.

Mr. ROWLAND. What other initiatives are you aware of that are being used or may be used to speed up this process up front?

Mr. MANGANO. I think one of the things that is being done very well in some States is that State Medicaid agencies have designated specific staff that would develop seminars throughout the State as well as go to the individual physicians' offices to talk with them about the Medicaid program, how can you improve the speed-up of your bills being paid et cetera.

Training programs in Michigan and Florida are particularly outstanding in that area. The State of Maryland has a really excellent program in which they have pediatric nurses go out and talk with physicians and encourage them to join the Medicaid program.

They talk with them about how the program operates, and they are available to the physician, once the physician has signed up for the program, if they have problems. That program in Maryland alone increased the number of providers available to treat young kids from—I think it was 375 to over 900 in 2 years. So, I think those kinds of initiatives are really very good.

One other thing that I think I would mention would be these troubleshooting guides that States put out. They say, look, we know there are going to be problems, we know that physicians are going to have some claims bounced back.

So, what they have done is put out some troubleshooting guides that say, if you have a problem, this is what you do. The State of Maryland has what they call a turnaround document. When a bill goes back to the physician because there is an error in it, the turnaround document clearly identifies what the error was, what the physician needs to do to correct it, and we will give them examples of how to correct that problem.

I think those are some of the things that we were particularly impressed with.

Mr. ROWLAND. What about the incidence of fraudulent claims? There is a significant incidence of fraudulent claims. How would the electronic system deal with that?

Mr. MANGANO. We think there are a number of ways the electronic system can safeguard that process.

The first thing that is happening in the States is that physicians would sign up in advance, before electronic claims are submitted. They would have an agreement with the State agency that the claims would be true and accurate, that they understand that they are liable for the claims.

The second thing is that the physicians would still maintain their medical as well as financial records in the office if an audit were required at a later date.

States can also assign a specific provider number, unique provider number for the physician, to ensure that those claims are coming from that particular physician.

Those are some of the ways that States have been able to safeguard their systems.

Mr. ROWLAND. What penalties can be assessed when a provider submits false claims or overcharges?

Mr. MANGANO. Well, what would happen in an incident like that is there would be an investigation, and if it, indeed, was a false claim, a couple of things could happen.

The State Medicaid fraud-control units—and they are, right now, in, I believe, 40 States—would investigate that case and turn it over for State prosecution.

As an example of that, last year, I believe there were about 640 convictions and over $26 million recovered because of false claims in general.

In those States that do not have a State Medicaid fraud control agency, the Inspector General's office would have responsibility to investigate those cases, and we do. We would prosecute them under the False Claims Act, most likely.

If a physician was found guilty of it and it was egregious enough, they could also suffer penalties by being excluded from both Medicaid and Medicare.

Mr. ROWLAND. Do you think this electronic claims system would in any way compromise the ability to impose penalties?

Mr. MANGANO. Not as long as the accountability factors were built in that I had suggested.

Mr. ROWLAND. You indicated that the majority of the coordinated care programs did not have intensive quality-assurance plans that include a review of medical records to determine if services were actually provided and were appropriate for the patient.

Do you believe that this should be an integral part of any QA program and required of all managed care programs?

Mr. MANGANO. We believe that more needs to be done in the States to ensure that we have some outcome standards built into the program. What we would like to see is more States involved in the complaint and grievance process.

At the current time, what most State Medicaid agencies do is tell the HMO that they are contracting with that you have to have a complaint and grievance procedure, you have to do patient satisfaction surveys, and that you have to—you should be doing outcomes research.

What we would like to see is the Medicaid agency itself more involved in that, so that we really do look at the outcomes of care in a far better way from the point of view of the beneficiary as well as the medical outcomes of the patient.

That is an area, of course, that has received a lot of national attention. We think, in the long term, those kinds of standards would really help improve the quality of care in those settings.

Mr. ROWLAND. Do you think that State Medicaid agencies' reviews of HMO's include an assessment of the quality of services that are provided?

Mr. MANGANO. Well, most of the reviews that are conducted by the State Medicaid agencies are paper reviews of materials that have been put together by the HMO's themselves. State Medicaid agencies themselves do not, for example—are not required to do medical reviews.

When medical reviews are carried out, they will require the peer review organization to do it, but we did not find a very activist position on the part of States to go in and look at the medical care being delivered at the HMO's. But they do require a number of items from the HMO's themselves that would be proxy measures for that.

Mr. ROWLAND. Should such a review be required of all HMO's and other coordinated care programs?

Mr. MANGANO. I'm sorry.

Mr. ROWLAND. A review, a review that we've been talking about by the Medicaid agencies, should it be required of all HMO's and other coordinated care programs?

Mr. MANGANO. We think long term that the investment that could be put into those kinds of reviews would be beneficial. It clearly would put people onto alert that the State programs and the Federal programs were very intent while making sure that the quality of care delivered to Medicaid beneficiaries would be as high as it possibly could be. So, I think there is a sentinel effect that speaks to that issue.

Mr. ROWLAND. Few States that you've looked at include patient surveys to determine whether the patient was satisfied with the services they got, whether the care they received helped them or whether there was any follow-up by the HMO. Do you believe that such surveys should be required to get an accurate picture of how well an HMO is doing its job?

Mr. MANGANO. We found that some of the most effective systems was where the State was involved themselves in having patient satisfaction and reviews. Only eight of the States required it of the HMO's. But I will also tell you that every HMO that we went to did have a patient satisfaction review survey themselves to be instituted because they wanted to know back from the patient. But we think that having the Medicaid agency involved in either directly administering a patient/client satisfaction survey or having firsthand involvement in looking at the raw data coming back to the HMO's would be a healthy improvement.

Mr. ROWLAND. We've talked a lot about Arizona today. I am happy to see Dr. Len Kirschner, who is director of Arizona's Health Care Cost Containment System, is with us today.

Thank you very much for being with us today. We do appreciate it.

Dr. Kirschner testified last October that their program required both practice guidelines and outcome indicators for the coordinated care programs in their State. Dr. Kirschner also testified that State officials visited the actual sites and visited with patients to verify that these requirements were being met. Both the administration's year 2000 objectives and Public Health Service Preventative Services Task Force recommended those same requirements. I have two questions. One, why are they not being done and, two, how can we possibly reach those objectives and assure good quality care without those evaluations?

Mr. MANGANO. I would speak very strongly in favor of having clinical practice guidelines. We think that is real important. Six of the States that were in our survey—6 of the 25 States that do contract with HMO's—do require the HMO's have clinical practice guidelines. We found some very basic evidence of some of them doing it.

Most of the HMO's do have some practice guidelines around the more serious illnesses, cardiac problems, things that are going to require very intense review. So, we would strongly endorse that. At the Federal level, the Agency for Health Care Policy and Research has been involved in developing these practice guidelines. They have now issued two of them. I know that they have a number of them coming up in the next couple of years. We think that development will be very good for improving overall medical treatment within the country.

Mr. Rowland. Well, with respect to the practice guidelines and outcome indicators, the Agency for Health Care Policy and Research is responsible for developing both. In 1990 our full committee mandated statutorily that those guidelines and indicators be developed. To date, only two guidelines have been issued, one on pain and one on incompetence.

Realistically speaking, if we continue at the current pace it could be decades before we have those practice guidelines; is that right?

Mr. Mangano. I would say so. There is clearly a need to move those up much faster than they are coming out right now. We find that the physician community around the country is interested in those as well as HMO's, other insurers, et cetera. People want it. It could have a very salutary effect, particularly in the area where we were talking earlier of malpractice. Having those guidelines out there and having physicians practice according to the guidelines, I think would probably provide them some protection against malpractice.

Mr. Rowland. As I understand it, other States, practitioners, insurers and accrediting organizations have developed practice guidelines for virtually all procedures. Wouldn't it make sense to evaluate those guidelines as quickly as possible and adopt them?

Mr. Mangano. I know that the Agency for Health Care Policy Research does use every available piece of information in coming up with those guidelines. I don't want to speak for them as to why they haven't come to their conclusions a lot sooner. I know that they do have difficulty in coming to consensus with a variety of groups that speak on particular issues. So, to your question should they be coming up faster? We certainly would like to see it come up faster. In terms of adopting State practice guidelines, I guess I'd have to—if I put myself in their position there probably are a variety of different guidelines around the country, and I think what they are trying to do is to come up with one coherent set that represents the best of everybody. I think that that is what their goal is and I think that is what is going to take the time.

Mr. Rowland. There will be some other questions that we will want to submit to you also. I am the only one who is here—everyone else is tied up with RCRA right now.

Mr. Bliley has asked that his statement be included in the record of today's hearing. We will do so at this time without any objection. We stand adjourned. Thank you very much.

[The prepared statement of Mr. Bliley follows:]

Statement of Hon. Thomas J. Bliley

Thank you, Mr. Chairman. I commend you for calling this hearing to continue the subcommittee's examination of the Medicaid program's impact on States.

The high cost of health care has been a primary topic of discussion at our hearings held thus far. That cost is reflected not only in dollars, but also in human lives. Nowhere is this more evident than in the area of infant mortality, where dollars spent on prenatal care can directly lead to reduced mortality and in turn to fewer dollars that must be spent in the future to keep children alive and healthy.

I understand that the national center to prevent infant mortality will issue at today's hearing its annual analysis of infant mortality figures, and that the news is not encouraging. Indeed, I understand the 1989 U.S. figure of 9.8 deaths for every 1,000 live births ranks us 22nd, just behind Greece and ahead of Israel, and far behind Japan's figure of 4.59.

To alleviate the problem of infant mortality I introduced H.R. 1968, the Consolidated Maternal and Child Health Services Act of 1991. This bill would take all the Federal moneys currently spent on family planning, nutrition services, prenatal care, delivery services, etc., and concentrate the moneys in block grants to the States. The States would make grants to providers who promise to offer all services at their location. This "one-stop shopping" concept has proved to be quite effective. Poor women who don't have the money or the time to travel all over a city or a county to receive their services will be able to receive them all at one location. They will become familiar with the people providing them services; thus retention rates will increase. I believe this is legislation we should swiftly enact.

I want to join with Mr. Bilirakis in welcoming Governor Lawton Chiles of the State of Florida. Florida has certainly not been immune from the problems of access to care, quality of care and cost of care about which we have heard from the States of Virginia, Oregon, Arizona and, most recently, Michigan. Indeed, what appears to distinguish the various States is not that they are facing such problems, but what they are doing about them. Many innovative steps are being taken at the State level, and I look forward to hearing about those taken by the State of Florida.

We will also be hearing from the HHS Office of the Inspector General, whose representatives have been frequent visitors to the witness table throughout this investigation. We will hear about how the inappropriate use of emergency rooms for primary care affects the quality and cost of care for Medicaid recipients; how managed care is used by various State Medicaid programs and whether it has affected access to care and quality of care; and about various administrative burdens that adversely impact recipients' access to and quality of care.

I look forward to today's testimony, to hearing more about States' approaches to Medicaid and what problems continue to confront them.

Thank you, Mr. Chairman.

[Whereupon, the hearing was adjourned at 12:07 p.m.]

[The following letter and statement was submitted for the record:]

EXECUTIVE CHAMBERS
HONOLULU

JOHN WAIHEE
GOVERNOR

March 23, 1992

The Honorable John D. Dingell, Chairman
Oversight & Investigations Subcommittee
House Energy & Commerce Committee
2323 Rayburn House Office Building
Washington, D.C. 20215-2216

Dear Chairman Dingell:

Thank you for the opportunity to discuss Hawaii's health care system and to look at the role of Medicaid in helping our state to attain nearly universal access. I hope our past experience and our plans for the future will be useful to members of Congress as you work to bring change to our antiquated health care system in America.

As many as 37 million Americans lack health insurance, and in our current economic climate that number is increasing. Nationally, we have health care statistics which, in many cases, match those of third world nations. Medical costs rise significantly each year, now encompassing about 14% of our nation's gross national product.

Years ago, people were terrified of illness because it often meant death. Today many of our citizens are still afraid of getting sick, but now they fear the cost of treatment more than the disease itself. It is clearly time to reform our nation's health system, before only the wealthiest can afford the cost of health care.

I believe Hawaii has much to offer the national debate -- we have learned important lessons through twenty-six years of Medicaid, seventeen years of employer-mandated coverage, and our recent implementation of a state subsidized insurance program for the remaining gap group. With these three programs, 100% of Hawaii's residents have access to affordable basic health care. Hawaii's experience in universal access at affordable costs will be of significant value in the development of a national health reform package, and in crafting a Medicaid program which is both cost-effective and responsive to the health care needs of our citizens.

Nationally, there have been many studies, reports and recommendations on how to deal with America's crisis in health care. These recommendations have focused on two paths, two basic strategies -- preserving the status quo or radically centralizing America's health care system. Bluntly put, I do not believe either of those will work.

The Honorable John Dingell
March 23, 1992
Page Two

Hawaii's experience supports a third path, one which would build on the strengths of America's health care system. This path, while requiring definitive leadership of government, calls for a true partnership with the private sector. In such a strategy, government establishes and enforces reasonable health care coverage standards for the nation to follow but allows the competitive marketplace to achieve those standards in the most affordable manner.

I have submitted to this Committee testimony on the components of Hawaii's health care system, with particular emphasis on our experience with Medicaid. I hope you will review it objectively. I have been told more than once that Hawaii is "unique" and what works for us will not work elsewhere. I disagree.

Despite our high cost of living, our system delivers high-quality care for low cost. We emphasize early intervention and outpatient treatment but also enjoy high-tech tertiary care programs as advanced as any state or nation. The key to our success, I would hold, is our state's longstanding commitment to ensuring that basic health care is available to all our people. We have committed ourselves to 100% access and at this point, have achieved about 98% coverage.

Our state has a mandated employer benefits program, the only one of its kind in the nation, a Medicaid program which reflects our people's high commitment to those in need, and coverage to the remaining "gap group" through our new, subsidized State Health Insurance Program (SHIP). We don't offer these programs as panaceas for the national crisis of the uninsured. But they are applicable to the national debate on health care.

I apologize to the Committee for not being able to present my testimony in person. I thank you for the opportunity to contribute to the critical work of rebuilding our national health care system. I pledge to work with you, your colleagues in Congress, my fellow governors, and the national administration to build a program which will meet America's health care needs.

With kindest regards,

Sincerely,

JOHN WAIHEE

STATEMENT BY
JOHN WAIHEE, GOVERNOR
STATE OF HAWAII

Hawaii's health care system has three components, employer-mandated coverage, Medicaid, and a state subsidized insurance program for the remaining gap group. These three programs provide access to basic health care to 100% of Hawaii's citizens.

HAWAII PREPAID HEALTH CARE ACT

The Prepaid Health Care Act was adopted in 1974 to provide health insurance and medical protection insurance for virtually all employees in the state. The Act is administered by the State's Department of Labor and Industrial Relations.

The Prepaid Health Care Law is the nation's first and only state mandated benefits plan. Employers are required to provide health insurance to their employees. Costs are shared. The employee may be required to pay up to 1.5% of monthly wages, up to half the premium cost. The employer pays the balance. Dependent coverage is optional. Under the law, employers may provide benefits through self-insurance as long as those basic services are provided. There are coverage alternatives, a fee-for-service plan and a health maintenance plan. The fee-for-service plan -- most used in Hawaii -- provides a good package of diagnostic and treatment services, using co-payments to reduce over utilization. The HMO provides a generous package of benefits.

Any employee who works over 20 hours a week and makes a minimum number of hours per month is eligible for Prepaid Health Care. Because the program is administered in conjunction with temporary disability and workers' compensation insurance, no large state bureaucracy was created to administer Prepaid Health Care. A Premium Supplementation Fund assists employers who cannot, because of economic limitations, provide the insurance, and to assist employees whose employers have gone out of business or who have not provided for the insurance. This fund has had minimal use over the 17 years of the program.

Excluded from the provisions of the Act are government employees (who have their own plan), seasonal agricultural workers, real estate and insurance agents working on commission, individual proprietorship members in small family business, and government assistance program recipients.

Prepaid Health Care has been very successful in bringing about coverage without negatively affecting business. Effects on unemployment have been negligible. In fact, the Act was implemented during a period of relatively high unemployment (in 1976, it reached 9.8%). Over the last 16 years our unemployment rate has fallen to the lowest in the nation (we make no claims about a cause-effect relationship in this regard, but this at least seems to cast some doubt on assertions that such mandates will cause unemployment).

In addition the Act does not appear to have an adverse effect on "start up" of new businesses. In 1989, for example, our small business incorporation rate increased 18.2%, making Hawaii the third fastest growing state in the nation for small business. Hawaii also ranks fairly low on company failures. This is particularly important because Hawaii is a small business state. About 97% of our businesses employ fewer than 100 workers and 94% have 50 or fewer employees. As you can see, our employer mandate has not had an overall negative effect on small business in Hawaii.

ERISA AND PREPAID HEALTH CARE

The Prepaid Health Care Act was passed just months before the Federal government passed the Employee Retirement Income Security Act (ERISA), which among its detailed provisions preempted state employer mandates. After long court challenges, special federal legislation was passed in 1983 which allowed the Hawaii mandate to continue. The exemption, however, used as its base the 1974 law. Since that time, Hawaii's health care environment has changed but the state lacks the ability under the exemption to amend the Act to reflect these changes.

While the 1974 Act still serves us well, we would benefit from the ability to change elements of the system which need updating. Such areas as coverage of dependents of workers, cost-share change between employer and employees (especially with respect to higher income employees) and benefits have been mentioned as possibilities for amending the Act.

COMMUNITY RATING FOR HEALTH INSURANCE

Because virtually all employers must provide insurance, Hawaii's major health care insurers (Hawaii Medical Service Association and Kaiser) maintain health insurance rates for small employers which are comparable to those enjoyed by large employers. This has happened because the two major health insurers in Hawaii (both non-profit) voluntarily use modified community rating for small businesses. This keeps rates for comparable coverage well below rates for small business elsewhere in the country (see Table 1). This form of community rating spreads risk across the entire small business population, as opposed to U.S.-mainland practices which focus on trying to fund and sell insurance to "low risk" people, leaving the "high risks," or those without the ability to pay high rates, without insurance.

The results have been extremely positive. Small business can purchase insurance at reasonable rates, and employees are covered with health insurance. Insurance companies cut administrative costs and can market to a large pool of businesses. Prepaid Health Care has provided a uniformly level field for competition, in which responsible small businesses who provide health insurance are not at a competitive disadvantage relative to those who do not.

MEDICAID

Hawaii, in 1966, was one of the first states in the nation to form the newly enacted Medicaid program. Hawaii's Medicaid Program services over 89,000 persons with a budget exceeding $360 million. It is administered by the State's Department of Human Services.

Overview of Medicaid Program

Projections indicate that our Medicaid caseload may exceed 90,000 by the end of the current fiscal year. Payments total $6.5 million per week. A rapid rise in recipients since the late 1980s altered a downward trend in caseload which existed during most of the 1980s. A great part of this expansion has rested on the Omnibus Budget Reconciliation Act (OBRA) options/mandates.

Hawaii has expanded Medicaid to include mandates included in the federal Omnibus Budget Reconciliation Acts, and has opted to expand eligibility for the aged and disabled. Hawaii's Medicaid program has a solid and comprehensive array of services accessible to the state's needy population.

Mandatory coverage groups

Certain groups must be covered by state Medicaid programs. These mandatory groups generally relate to two broad categories:

1. **Low-income families with dependent children.**
   Historically, this group has been composed of families receiving cash assistance through the Aid to Families with Dependent Children (AFDC) program, but recent legislation has expanded Medicaid eligibility in this area to include other low-income families.

2. **Low-income aged and disabled.**
   Generally, this group includes individuals receiving cash assistance through the Supplemental Security Income (SSI) program and certain SSI-related groups.

3. **Medically needy.**
   Our state also chooses to cover the medically needy. The medically needy are individuals whose incomes or resources are above levels generally required for eligibility but who have incurred large medical expenses.

In this program, "low income" eligibility is defined as those who are at or below 62.5% of the federal poverty level. This threshold represents the program's medical needy standard of assistance. To engender program effectiveness, AFDC also utilizes the 62.5% figure as its threshold level.

Mandated services

Title XIX of the Social Security Act requires that every state Medicaid program offer certain basic services:

> Inpatient hospital services, outpatient hospital services, laboratory and x-ray services, SNF services for individuals 21 years of age or over, home health services for individuals eligible for SNF services, physicians' services, family planning services, rural health clinic services, nurse-midwife services and early and periodic screening, diagnosis and treatment services (EPSDT) for individuals under 21 years of age.

Hawaii's optional services

In addition, states may elect to provide a number of other services. In Hawaii, we provide 24 optional services. They include the following:

> Podiatrists' services, optometrists' services, other practitioners' services, clinic services, dental services, physical therapy, occupational therapy, speech/hearing/language disorders, prescribed drugs, dentures, prosthetic devices, eyeglasses, diagnostic services, screening services, preventive services, rehabilitative services, ICF for the mentally retarded, inpatient psychiatric (for those under 21 years of age), NF services (for those under age 21), transportation services, hospice care services, respiratory care services.

Payment process

Medicaid is a vendor payment program; payments are made directly to providers of service for care rendered to eligible individuals. Providers who choose to participate in the program must accept the Medicaid reimbursement levels as full payment. States have wide latitude in choosing methods of provider reimbursement. In Hawaii, the Hawaii Medical Service Association (HMSA) is the fiscal agent for the program. HMSA processes and pays 95% of Medicaid claims through its system. The state sends payments to HMSA who in turn processes health care provider reimbursement claims and pays them on a weekly basis.

General Assistance Program

This program provides assistance for low-income and non-Medicaid eligible adults. The total service population is near 8,000, and the program is wholly State funded at $45 million. These individuals receive medical benefits identical to those of the federally subsidized Medicaid program.

We are currently reviewing our General Assistance program with an advisory committee composed of State agencies, provider organizations and consumer representatives to develop a more cost-effective system of care delivery. Hopefully, together, we can develop changes which can be integrated into our overall Medicaid program.

HAWAII POPULATION WITHOUT HEALTH CARE INSURANCE

In 1971, a survey showed that almost 12% of our population was without hospital insurance and 17% without physician insurance. With Prepaid Health Care, this figure dropped dramatically to about 5% of Hawaii's people.

Gap Group

In defining the "gap group," we focused on people who are not insured by public or private health care coverage programs and whose income is low enough that they cannot buy regular health care insurance. The number was estimated to be between 60 and 70% of the total uninsured.

Populations at risk in the gap group are those who, for one reason or another, lack access to Prepaid Health Care. A 1988 survey found the unemployed make up more than 30% of Oahu's uninsured. (The main Island of Oahu has 80% of the State's population.) This is probably true of the neighbor islands, too. Dependents of low-income workers, particularly children, are another major gap group. Part-time workers, excluded from Prepaid Health Care, are another population at risk. Neighbor island residents, immigrants, seasonal workers and students are also at risk, although they are not formally excluded from Prepaid Health Care.

Dealing with the Gap Group

Hawaii addressed this gap through a two-part strategy. For those persons able to qualify for the optional (later mandatory) expansions of Medicaid for high priority groups such as pregnant women and infants, the State took advantage of the OBRA options through the late 1980s and early 1990s. For those above the poverty level or who could not be addressed by Medicaid, the State created a subsidized "gap group" insurance program, the State Health Insurance Program, or SHIP.

Expanding Medicaid

Hawaii has implemented all Congressional mandates related to services for mothers and children, nursing home reform, EPSDT, and programs for the aged and disabled. The following are the detail of the respective Acts.

> Per the **Omnibus Budget Reconciliation Act (OBRA) of 1986**, the Medicaid Options to Mothers and Infants (MOMI) program expanded eligibility for pregnant mothers and infants by increasing its income threshold to 185% of the federal poverty level and eliminating asset limitations. This expansion translates into $11.9 million for FY 92 and $13.8 million for FY 93.
>
> Eligibility levels for children, the aged, and disabled were also expanded by increasing the income threshold for eligibility. This translates into funding exceeding $110 million. The expansions are displayed in the following chart:

Age	% of Federal Poverty Level
Up to age 6	133%
Up to age 9	100%
(With an additional year to be added until age 18)	
Aged and disabled	100%

OBRA 1987 -- also known as the Nursing Home Reform Act -- increased long-term care expenditures via implementation of new requirements such as nurse aide training/competency evaluation activities and more stringent facility requirements. These adjustments represent over $30 million of the budget in FY 92.

OBRA 1989 mandated the EPSDT program for children under age 19 in all states. It provides coverage for services not ordinarily provided by the Medicaid program. Expenditures for FY 92 are estimated to exceed $6 million. However, as providers become more familiar with the program and the AFDC population increases, it is expected that the program will see the number of severe and expensive cases increase.

Also mandated was 100% of reimbursement based on reasonable costs to federally qualified health centers (FQHCs) and their "look alikes." Hawaii has two FQHCs and one "look alike," with two additional FQHCs awaiting certification. The cost impact of these centers are unknown at this time.

OBRA 1990 mandated increased premiums, co-insurance and deductibles for Medicare Part A and B. Medicaid pays:

1. The Part B premiums for all Medicare-enrolled Medicaid recipients;
2. Part A premiums for those Medicaid recipients who are paying such premiums out of their own pocket;
3. Co-insurance; and
4. Deductibles.

Part A premiums, co-insurance and deductibles are projected at $4.7 million for FY 92 and $6 million for FY 93.

As can be noted, these expansions were fiscally significant for the State. While coverage was significantly expanded from approximately 67,000 persons in 1988 to almost 90,000 now, costs have increased from $176 million in 1988 to $360 million in

1992. The challenge for us, as for the other states, is to maintain these gains on Medicaid access while still dealing with the increasing problems of costs.

STATE HEALTH INSURANCE PROGRAM (SHIP)

The State Health Insurance Program builds upon Hawaii's Prepaid Health Care Act and Medicaid. SHIP is not expected to duplicate the coverage in either program, rather, to serve as a flexible means of addressing gap group needs.

SHIP's mission is to subsidize affordable health care coverage, encourage use of private insurance and Medicaid and discourage shift to SHIP from private coverage. This makes SHIP a partnership between government, individuals and families, and the private sector. Most individuals pay their own premiums, a sliding scale based on their ability to pay. Government subsidizes insurance premiums for those unable to pay. Insurance companies provide the coverage and the already existing health care providers deliver direct care. This is much like the model adopted by the State of Washington in its pilot Basic Health program.

Key to the construction of this "basic benefits" program is the nature of the clientele it seeks to serve. Given the early results of Basic Health and the numerous studies done by the Robert Wood Johnson Foundation, it was felt that the gap group was essentially young, generally healthy, and determined to "stay off welfare." In short, good risks for insurance. Benefits were designed for this group to emphasize prevention and early primary care to keep those already healthy in good health. Because of its costs, catastrophic care was de-emphasized and those needing primary care were directed toward Medicaid.

Benefits

Benefits of SHIP are heavily weighted toward preventive and primary care, with health appraisals and related tests, well baby and well child coverage and accident coverage fully covered. Twelve physician visits are allowed with a $5 co-payment during the course of the year. An individual's hospitalization, however, has been limited to five days. Two days are allowed for maternity care. Elective surgery, and high-cost tertiary care have been excluded. The program assumes that most members of the gap group will qualify for Medicaid after exercising "spend down" for these costly procedures.

Costs

The insured's share is based on a sliding fee scale where individuals pay a portion of the cost on a monthly basis and are billed directly by the insurance company. This fee scale (Table 2) is based upon ability to pay. Persons below the poverty level pay no fee and the monthly charges for those above poverty increase with income level. Co-payment at the time of a non-prevention visit is $5 and is required for all subscribers.

SHIP Carriers

SHIP insurance is delivered through contracts with the State's two largest insurers -- HMSA, which has about 55% of all health insurance in Hawaii and Kaiser Permanente, which has about 17%. Both have cooperated enthusiastically in this program.

The HMSA contract covers the bulk of SHIP's subscribers with a statewide fee-for-service plan, although we do propose HMO coverage be developed. Almost one-half (about 1,000 physicians) of the state's physicians have signed on to participate in SHIP through HMSA. Only 20% of SHIP's funds can be used for in-patient hospitalization. The philosophy adopted is that hospitals provide for care for this group already -- much of this is uncompensated. The additional funding, even if it does not cover the whole cost of care, will assist the hospitals in providing for their needs.

The Kaiser contract is limited to 3,500 subscribers on the island of Oahu. Kaiser subsidizes a portion of the costs of the coverage for their full health maintenance coverage for these people.

Program Implementation

SHIP was launched statewide on April 16, 1990. From the beginning, the objective has been to eliminate the barriers and red tape which often deter the genuinely needy from getting government services.

Our major task has been to bring people into SHIP, to target what would be in any state perhaps the most difficult to reach, those people who are outside of the system. We have emphasized the non-traditional, with shorter application forms, instant access for special groups (pregnant women), and special outreach efforts to hard-to-reach groups such as immigrants.

The results have been impressive. As of March 1, 1992, we have an enrollment level of 12,500 members in HMSA-SHIP and 3,300 in Kaiser-SHIP. As expected, SHIP members are, in general, young (43% are under age 18). Outreach in rural areas appears to have been successful -- almost 48% of SHIP clientele is from the generally rural neighbor islands. Sixty-five percent (65%) of SHIP membership has family income below the federal poverty level, with almost 85% of the membership below 150% of the poverty level. Program utilization, given our short experience, appears to be good, with indications that SHIP's members use the program benefits less than the regular members of the two participating health plans. Program expenditures are budgeted at about $10 million each year of the 1991-93 fiscal biennium.

REACHING TOWARD UNIVERSAL COVERAGE

Medicaid has grown with the OBRA-related expansions to 89,200 persons at the end of February 1992. This represents an increase of over 22,000 persons (33%) over the 1988 level. SHIP's membership is now about 16,000. Together, Medicaid and SHIP are serving over 38,000 persons. Because this expansion reduced our already low 5% rate of the uninsured, our current rate of health care coverage is approximately 98% -- the highest level of coverage in the nation. With our combination of employer-based coverage, Medicaid and SHIP, as well as federal programs such as Medicare and CHAMPUS, Hawaii offers near universal access to health care coverage to all its people.

Benefits of Near Universal Coverage

The first, and most important, benefit of near universal coverage is in the human dimension. People in Hawaii do not worry about not being able to pay the doctor or hospital when they get sick. The security of having health care coverage for oneself and one's family allows people to go in for medical care when it's needed. In Hawaii, we often take for granted security many Americans now lack.

Second, our system makes primary care available to our whole population. Such early care has historically been emphasized by Hawaii's physicians. Today's modern practice patterns in Hawaii reflect this orientation. Our Prepaid Health Care Act made it possible for most people living in Hawaii to finance this care. Today, our health indicators show the results of primary care. We have the lowest infant mortality in the nation (along with Vermont) and low rates of premature death due to heart disease, cancer and lung disease. Our people are healthier not because of unique genetics, healthy climate or high tech medicine, but because they have access to primary care.

Another benefit flows from ready access to primary care -- we use high-cost services less than elsewhere in the United States. Our rate of hospital beds for our population is one-half the national average and our use of these beds is one-third the national average. Emergency room use, another expensive alternative to the family physician, is third lowest in the nation and one-third the national average. In short, primary care not only keeps us healthier, it also is cheaper.

Fourth, near universal coverage results in low uncompensated care costs for our hospitals. These costs are shifted to the insured sector of the population across the nation. Our low rates, as attested to by our Healthcare Association of Hawaii, mean that there is less shifting of this significant (and less controllable) cost to the insurance rates the rest of us pay.

Finally, our near universal coverage makes cost controls used by insurance companies more effective. Hawaii's major insurers use a variety of managed care techniques. The fact that the cost of care for so many of us is managed has resulted in a lower proportion of our state's resources being directed toward health care. A recent study suggests that Hawaii's health care share of gross state product was 8.1% in 1988 compared with health care's share of the United States GNP pegged at 11.1% that same year. While we live in one of the highest cost environments in the nation, our health care costs do not seem to consume as great a portion of our social product as they do at the national level. With an American health care system and an American system of health care finance, our state is achieving cost results similar to those of Canada.

NEED FOR CONTINUING REFORM

While our system has resulted in significant benefits for Hawaii's people and, we believe validates a number of policy directions for the nation, we do not have a problem-free utopia. Our system guarantees financial access to health care services, but it does not guarantee that those services will be rendered to all. Such factors as rural residence, provider reimbursement and cultural barriers still keep people from needed health care. Moreover, while basic services are available to all, some services (some preventive services in employer-based coverage, catastrophic coverage in SHIP, special services such as case management for the mentally ill) are not available in all coverage.

Costs, while they may be lower overall than anywhere in the nation, still are a problem. Costs of health care have been increasing in Hawaii, and frankly, while our cost containment mechanisms are working, it is clear that there is much more to do. With particular emphasis on Medicaid, our expanded caseload and increasing costs required an additional appropriation of $64 million this year to continue the program at current levels of benefits. This is a major increase in costs, one that threatens our best efforts at economy. Less severe but no less serious increases face employers, unions and consumers. I have appointed a Blue Ribbon Panel of community, business, labor and health care leaders and a Subcabinet Task Force to study this problem of cost increases so that we can take effective action soon.

Finally, it is clear that unless we comprehensively address long-term care financing, we will be unable to provide access to our elderly and curb the cost of rising dependence on Medicaid. Hawaii's Executive Office on Aging has taken the lead in developing the Hawaii Family Hope Program - designed to cover 80% of the cost of institutional, home and community-based long term care. We are currently seeking federal authorization and demonstration dollars, and will be seeking waivers in the near future. Hawaii's elderly population is growing nearly three times as fast as the rest of the nation. Our initiative is driven by our needs; and may well set an example for what is possible in the rest of the nation.

HAWAII'S EXPERIENCE AND THE NATIONAL PROBLEMS OF HEALTH CARE

Hawaii, almost twenty years ago, embraced one of the major measures suggested now for national health care reform. We remain the only State to have enacted this or any such system-wide change. While Hawaii does have its unique characteristics (as does each state), our health care system and people are so similar to the rest of the nation in essential aspects that our experience bears strongly on national health care reform policy. Our experience show that:

Primary health care works, not only to resolve health needs, but to contain health care costs.

Our low rates of premature mortality for chronic diseases, despite rates of incidence similar to national levels, shows that health care availability does cut down on mortality, irrespective of any genetic differences. In short, it keeps us healthier longer. In addition, it keeps us out of expensive emergency or inpatient care, reducing health care costs.

Mandated employer coverage can be an effective tool for universal access -- without negative impact on business.

Hawaii's employer mandate brings large numbers of our people under the umbrella of health care coverage. While this approach is sometimes criticized as being "anti-business," it actually is in accord with America's faith in the free enterprise system to find cost-effective solutions to complex problems. Through an employer mandate, government defines the extent of coverage and uses the competitive marketplace to provide that coverage cost effectively and efficiently. By requiring employers to cover their employees, an employer mandate avoids complex governmental bureaucracies and allows business to get the job done well. Our experience demonstrates this point.

In Hawaii, we do not have a "pay or play" system with its attendant tax. In Hawaii, "everybody plays." All employers are required to provide coverage -- a solid standard benefit package. Government enforces that coverage. However, in our system, employers are allowed the flexibility to determine how coverage is provided. This program has lowered the rate of people without medical coverage from more than 17% in 1971 to about 5% in 1988 -- and kept costs down.

Contrary to small business fears, our mandate has not brought about a bad business climate. In our small business state we have one of the highest small business creation rates in the nation and are about average with respect to business failures.

One of the key features of our system is its simplicity, and it has become evident to us that a major area of interest is this simplicity. I can't tell you how surprised and pleased we've been with the interest expressed by you and your Congressional colleagues as well as major public interest groups in sharing the specific experiences relating to our employer mandate. Undoubtedly, it is indicative of this interest and support which the Hawaii system has nationally that has led to our being exempted in successive major proposals entertained by Congress.

Using an employer mandate to cover a large number of the persons who would be otherwise uninsured, government can create affordable, responsive public coverage systems for the remainder.

Because Hawaii's gap group was reduced to 5% by Prepaid Health Care and Medicaid, we were able to implement Medicaid expansions and initiate a SHIP to provide subsidized insurance for the uninsured which guaranteed universal access to health care coverage in Hawaii. While Medicaid costs are growing at an alarming rate and SHIP can be improved, we have been able to design a system which does in fact provide coverage to 98% of our people. We would not have been able to manage this without coverage of our workers through our employer mandate.

We have also learned that insurance reform is vital to the success and equity of an employer mandate. What is also quite clear is that an employer mandate helps to ensure that insurance reforms are successful.

It is only fair that a mandate be accompanied by affordable insurance rates, which are possible in Hawaii through community rating, and the appropriate prohibition of such practices as exclusions and non-renewability. Our community rating is voluntary, a likely product of the important role of two large non-profit organizations in Hawaii's market. This modified community rating system works to keep our rates among the lowest in the nation -- essential in a state with a preponderance of small business that could not afford ratings based on the same factors that govern coverage in most other jurisdictions. The insurers have been able to maintain this system without a specific legislative mandate because all employers must purchase coverage. Because all employers are in the risk pool, community rates are affordable. Because the insurance companies must compete, the market, not governmental control, keeps the rates competitive.

Hawaii shows that states are important actors in affecting health care reform.

Thanks to its ERISA waiver, Hawaii, though a small state, has demonstrated that an employer mandate can be successful in reducing the numbers of uninsured and in constructing a system that works to provide coverage and restrain costs.

Other states want to take action to deal with their problems of health care access and cost. States should be given more tools to address their own internal health care problems -- tools such as ERISA waivers and Medicaid/Medicare flexibility. With these tools, state actions will not only respond to the immediate problems of individual states, but will help with national solutions.

RECOMMENDATIONS FOR NATIONAL HEALTH CARE REFORM

Hawaii's experiences suggest that a workable national solution could contain the following:

1. **An employer mandate.**

   With business already providing for the lion's share of health care coverage, it makes good sense to build upon that coverage. Our experience has shown that such a mandate need not be burdensome for business, and can be done with minimal government presence to level the playing field. On the other hand, a non-employer based system, one based on tax support, will tend to centralize control in government, and will likely reduce incentives, provider satisfaction, and consumer choices.

2. **Measures which ensure the availability of reasonably priced insurance for business.**

   A mandate which forces business to pay the high costs it is currently bearing in the rest of the United States will not work. The insurance system must be reformed to ensure that insurance is available to all, at reasonable cost. Requirements ensuring that community rating be done for health insurance, that insurance have not waiting period or coverage exclusions, and that any deductibles or co-payments not be a disincentives for necessary care are all necessary if the insurance system is to work. These ends could be met by certain types of single payor systems, but we would be concerned about single payor systems which centralized the major insurance functions in a governmental agency which eliminated competition among insurance companies, which we feel, adequately structured, would control costs.

3. **Improvements in the medical practice and tort systems.**

   The cost of defensive medicine and medical liability concerns significantly drive up the cost of health care. They are joined by over utilizing of health care services. Reasonable changes in the medical tort liability system and the establishment of practice guidelines by the involved professions themselves will significantly address the problems associated with this area.

4. **Cost-control measures.**

The three big areas of significant potential cost-containment once again relate to reductions in administrative costs, reductions in defensive medicine and excessive high tech costs, and in targeted reductions in emergency room and inpatient utilization through appropriately-reimbursed and accessible primary care and prevention services to all persons not being served. Additional cost controls will come with better "managed care" systems and competition among insurers to provide government-mandated standard benefits at the lowest cost to business. Additional institutional changes should follow these two principles:

1. **Any single payor system should not be designed to result in an all-powerful federal agency under the control of government.**

   In Hawaii, the competition between private non-profit insurers has resulted in a responsive system, with minimal bureaucracy -- a system which has resulted in significant cost control. While we still can better control costs, we believe that, to the greatest extent possible, control of such payment mechanisms should rest in the private sector. This does not argue that some central cost of information and administrative overlap should not be undertaken. Rather, it suggests that such a system should exist as a service agency to multiple payors. By so doing, it would take advantage of the economies of scale while still harnessing the competitive energy of multiple payors.

2. **Any cost control system must begin with the consumer and involve and states.**

   In our efforts to structure mechanisms to control costs, we must emphasize that the most important cost-controlling mechanism is informed human choice. Not only must consumers be educated about making cost-effective health care choices, they must be empowered by whatever mechanisms are created to be an active part of the solution. States represent important problem-solving capacity as well as constituting the formal legal and operational functions of providing for the health and safety of their people. Ignoring either of these in a national solution will make that solution incomplete.

INCREMENTAL CHANGES

We strongly support national health care reform this year. However, until consensus can be achieved on a national policy of universal access, we recommend three basic policies be enacted immediately to enhance the roles that states play in policy development. These recommendations would alter current Federal policies or programs which tend to inhibit state capacity for experimentation. In this concept, we propose the following to enhance the respective state's capabilities to develop individual responses to the crisis of the uninsured:

1. **Allow waivers or exemptions from ERISA restrictions on state-mandated employer coverage.**

   ERISA freezes the Hawaii Prepaid Health Care Act at the 1974 level. This impedes the growth of innovative changes to our program. Allowing waivers or exemptions from the ERISA restriction, such as proposed in Senator Akaka's legislation (S 590), will allow Hawaii and other states to experiment with mandated benefits and closely evaluate the results. For example, a state might wish to mandate only large employers to cover their employees and compare itself with other states like Hawaii which cover most of the employed within their boundaries. Similarly, the effects of various benefits packages, the impact of different cost sharing arrangements, or the changes brought about by insurance market reform could all provide for more informed decisions at the national level.

2. **Reform Medicaid.**

   The current Medicaid system is a patchwork of Federal mandates and options, linked together with heavy doses of administrative restrictions. States must sometimes wait long periods of time for waivers and changes in state plans to be approved by various HCFA offices. In order for Medicaid to be more responsive and flexible, we recommend the adoption of changes suggested by the National Governors' Association last year at their summer meeting. These changes should help this vital Federal/State partnership to succeed in providing for the needs of America's needy.

3. **Allow for significant state latitude in program development and implementation.**

The states remain inventive and important actors in this process by developing new models and systems of delivery. By sharing this innovation, states contribute to policy development. For example, SHIP has greatly benefitted from working with Washington State's Basic Health plan. Even with implementation of Federal policies, the states should be given the flexibility to continue as major actors. Any future Federal health care legislation should be formulated on the basis that the Federal programs are safety nets and do not preempt state programs which seek to provide better benefits to their citizens. In fact, new Federal/State partnerships should be explored, such as possible joint projects for Medicare recipients. Through this principle, states can be encouraged to continue in the forefront of policy development in health care finance.

As I have noted, Hawaii shows that health reform can be accomplished and can still maintain the basic strengths of America's health care system -- the cost-effective role of business, the innovation in prevention and treatment by health care providers, and the flexibility of financing of the health insurance industry. We all seek these same ends.

Attachments

TABLE 1

COMPARATIVE DATA OF HEALTH INSURANCE PREMIUMS

Small Business Group Insurance Rates, 1990:

	Single	Family
Hawaii	$94	$263
New York	$154	$360
Kansas	$282	$564
Delaware	$240	$516
Georgia	$140	$340
Arizona	$140	$335
California	$141	$503
Iowa	$139	$313
Illinois	$150	$415
Massachusetts	$217	$508

Benefits among these plans vary, although they all represent comparable comprehensive health plans. Please note that no two plans are exactly the same, and plan benefits should be considered before making any direct comparisons. For example, small business plans of the Continental U.S. tend to use other factors as part of their rating criteria, such as age, sex, occupation, and location.

In Hawaii, federal employees may choose among the following plans; all are offered by Hawaii based carriers, except the national plan. The plans all have similar benefits.

Federal Health Insurance Rates:

	Single	Family
Hawaii plans:		
HMSA Plan 4	$125	$332
HMSA CHP	$152	$416
Island Care	$161	$402
Kaiser	$141	$338
National Plan	$334	$706

TABLE 2

SHIP SLIDING FEE SCHEDULE

Family members	Annual gross income under	You would pay monthly for each	
		Adult	Child
1	$7,244	$ 0	
	9,030	10	
	10,836	15	
	14,448	20	
	18,060	40	
	21,672	60	
2	$9,684	$ 0	$ 0
	12,105	10	5
	14,526	15	7.50
	19,368	20	10
	24,210	40	15
	29,052	60	20
3	$12,144	$ 0	$ 0
	15,180	10	5
	18,216	15	7.50
	24,288	20	10
	30,360	40	15
	36,432	60	20
4	$14,604	$ 0	$ 0
	18,255	10	5
	21,906	15	7.50
	29,208	20	10
	36,510	40	15
	43,812	60	20

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